# OFFICE OF THE INSURANCE COMMISSIONER

## REPRODUCTIVE HEALTH BENEFITS SURVEY

## INTRODUCTION
### An Overview of Reproductive Health and Health Insurance

Reproductive and sexual health are considered by many to be essential components of overall health for individuals and communities. The ability to manage one's fertility, have healthy pregnancies, avoid sexually transmitted diseases (STDs) including human immunodeficiency virus (HIV/AIDS), and to access screening services for early detection of reproductive cancers, are accepted by public health experts as important to maintain the health of women and men.[1] As with any other health area, whether individuals *are* able to access these important services in a timely and effective manner has been shown to be heavily influenced by whether they have some form of financial coverage - either private or public insurance.

Many people expect that a comprehensive health insurance plan will provide coverage for those health care services most relevant to reproductive and sexual health. By reviewing public demand and expectations as well as professional standards of care in these areas, the OIC identified a series of services that are important to consider. These include routine gynecological, maternity, contraception and family planning, pregnancy termination, infertility, reproductive cancer screening, STD/HIV, and sterilization service coverage. In addition, the OIC identified an overwhelming public concern that access occurs in a manner that protects the confidentiality of health information related to these often-sensitive services. This survey was designed to answer the question: to what extent do the health insurance plans marketed in Washington State make these services available?

Assessing reproductive health coverage in private, i.e., employer-sponsored, plans is important because over two-thirds of women in the United States rely on employer-related health plans (their own or through a family member),[2] yet little is known about the coverage of those benefits germane to women's reproductive and sexual health. (Much more is known about publicly-sponsored plans such as Medicaid, many of whose benefits are mandated, than is known about private-sector coverage.) A gender inequity may exist when health plans exclude reproductive, contraceptive, and sexual-health-related services for which women alone bear the burden of need (such as pregnancy and its outcomes). In Washington insurance benefits provided by employers must be equal for male and female employees.[3]

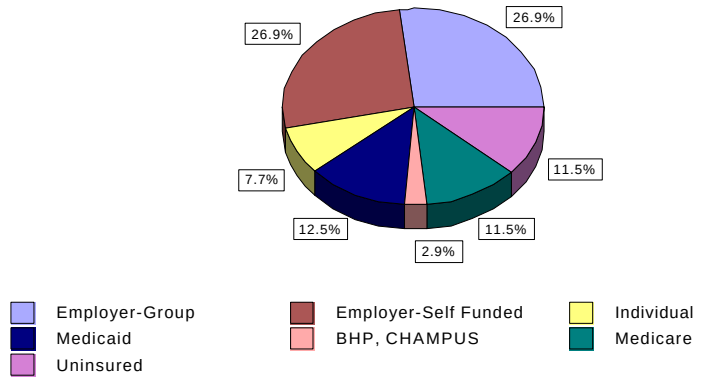
Only two national studies have been conducted to assess private-plan reproductive health benefits, and these largely focused on contraceptive services. One 1996 survey by the Alan Guttmacher Institute of commercial and Blue Cross companies and HMOs found that almost half (49%) of the typical large-group plans did not cover contraceptive services at all.[4] The second national survey of public and private employer-sponsored health plans showed that 32% of the HMO, and 56% of the indemnity plans, exclude contraceptive drugs; over half of HMOs and two-thirds of indemnity plans

exclude contraceptive devices.[5] This OIC survey appears to be the only state-level study yet conducted to document reproductive health benefits in private and public health insurance plans.

Several general trends in health insurance coverage are worth noting to put this survey in context. The proportion of people who have private (employer-sponsored) insurance is dropping in the US. Higher rates of employment historically correlate with high rates of insurance, but today this is no longer the case: while employment rates are at an all-time high, many employers are increasing employees' costs for coverage or are dropping health insurance coverage altogether, and many workers are moving into businesses that do not offer health insurance. While there has been job growth in Washington State, much of it has been in the specialized employment of high-technology fields, or in service industry jobs that tend not to sponsor health insurance.

National data show that women of reproductive age spend 68% more on out-of-pocket health expenses than their male counterparts. Women of childbearing age paid 56% of the cost of contraceptives out of-pocket in 1993.[6] Women are more likely than men to participate in Medicaid, which may in part explain why slightly fewer women than men have lapses in health insurance coverage: in the United States 24% of women and 27% of men were without health insurance for at least one month from 1990-1992.[7] Significantly, even though services for low-income women generally are subsidized, the average out-of-pocket payments for reproductive health services are the same for women with incomes below and above 200% of poverty level.[8] Around one in ten Washington women did not have health insurance in 1994, and 12% reported that they were unable to see a doctor because of cost.[9]

**Figure 1: Washington Health Insurance Sources, 1995**




The majority of Washington's citizens receive their health insurance coverage through employer-sponsored plans (see Figure 1).[10]

For persons who receive employment-based health insurance, the reality is that the purchaser (in this case, the person's employer) determines what kind of benefits employees will get. Three-quarters (75%) of Washington State employers offered only one health plan for their employees in 1993; this was higher than the national average of 67%.[11] As a way of controlling costs, more people are being moved into managed care, both in Washington State and across the nation.

## SURVEY BACKGROUND

This survey arose from consumer demand. During the time period of January through October of 1997, the Office of the Insurance Commissioner (OIC) received 145 consumer complaints related to reproductive and sexual health service coverage in health plans. Advocacy organizations also have called for improving women's access to family planning services. Prior to this survey there have been

little data available by which to measure the extent to which women and men are able to obtain key reproductive and sexual health services as covered benefits under their health plans.

## Survey Methodology

The sampling universe for this survey was the approximately 40 health insurance carriers licensed to do business in the state of Washington. Surveys were sent to a sample of eighteen (n = 18) carriers. These carriers were selected to be representative of geographical distribution, plan and carrier type, enrollment size, and as having a market share that covered a majority of those Washington State residents with both private (commercial) and public (government-sponsored) health insurance.

The survey tool was designed based on a keyword listing of OIC consumer complaints, and on the instrument used by the Alan Guttmacher Institute. Carriers were asked to describe the covered benefits in their five best-selling group plans, and two best-selling individual plans. The instrument was beta tested using a representative carrier for feedback, and distributed by mail in October 1997. Carriers were given phone follow-up as needed to clarify questions and answers.

Of the eighteen carriers surveyed, valid responses were received from 16 carriers including ten health care service contractors,[a] four health maintenance organizations[b] and two insurance companies marketing health insurance products.[c] Two insurance companies did not complete the survey because they were not selling policies in the state of Washington. Respondents included eight of the state's ten largest carriers, and 14 of the largest 25 carriers, whose total (not just surveyed) plans have an *overall* combined market enrollment of 2,572,406 Washington residents, or around half of the state's population.

The carriers who responded to the survey in the fall of 1997 were:

- Aetna US HealthCare
- Blue Cross of Washington and Alaska
- Community Health Plan of Washington
- First Choice Health Plan
- Group Health Cooperative of Puget Sound
- Group Health Northwest
- John Alden Life Insurance company
- Kitsap Physicians Service
- Medical Service Corporation
- National Health Insurance Company[d]

[a] "Health care service contractors" refers to organizations that contract with health care providers for the benefit of health plan enrollees.

[b] "Health maintenance organizations" offer prepaid, comprehensive health coverage for hospital and clinician services.

[c] "Life and disability insurer" means any insurance company authorized to write life insurance, disability insurance, or both, as defined in chapter 48.11RCW. RCW 48.05.430(5) "Disability insurance" is insurance against bodily injury, disablement or death by accident, and against disablement resulting from sickness.

[d] National Health Insurance Company reported that they were not actively marketing their product in Washington in fall 1997.

- New York Life Insurance Company
- New York Life and Health Insurance Company[a]
- Pacificare
- Providence Health Care/The Good Health Plan of Washington
- Qual Med Health Plan
- Regence Blue Shield
- Sisters of Providence Good Health Plan of Oregon
- Skagit County Medical Bureau

Initial responses were entered into an Excel database and compiled for a Preliminary Report that was released January 16, 1997.

By the summer of 1998 several mergers had taken place among these carriers, so all the carriers were resurveyed to confirm the validity and current accuracy of the survey responses as of June 1998. The benefit descriptions provided by carriers in October 1997 were incorporated into the questionnaire to outline the specific services most often mentioned as a standard of care. "Core" services were further defined based on national guidelines from the US Preventive Services Task Force (1989), and professional association recommendations where relevant. Please see Appendix for the survey instrument. Data were encoded[b] and tabulated in an Excel database in June and July 1998.

Carriers were informed that the survey results might contribute to the development of future OIC policy, and that the final results would be summarized and published by carrier and plan name. Post-merger carriers included in the final data analysis are:

- **Aetna** (previously-named Aetna US HealthCare; includes former New York Life Insurance Company)
- **Premera** (previously-named Blue Cross of Washington and Alaska; includes former Medical Service Corporation)
- **Community Health Plan of Washington**
- **First Choice Health Plan**
- **Group Health Cooperative** (previously-named Group Health Cooperative of Puget Sound; includes former Group Health Northwest)
- **John Alden Life Insurance company**
- **Kitsap Physicians Service**
- **Pacificare**
- **Providence Health Care** (previously-named Providence Health Care/The Good Health Plan of Washington; includes former Sisters of Providence Good Health Plan of Oregon)
- **Qual Med Health Plan**

[a] New York Life and Health Insurance Company operating forms were not yet approved by the OIC in fall 1997.

[b] In most sections of the survey, carriers were asked whether enrollees had "Direct Access", i.e., are able to self-refer to a women's health provider, as mandated by RCW 48.42.100. Responses were coded as 'Yes' if women were able to self-refer. Carriers were asked whether there are "Copays, Coinsurance, or Deductibles" associated with the service. Responses were coded as 'Yes' if any copay applied; in many cases this was the standard office visit or prescription copay. A note was made in the "Notes" column if a specific or higher than standard copay was applicable. Where specific services were not part of the standard benefit package, carriers were asked if they offer these services as a rider.

- **Regence Blue Shield** (previously-named Regence Washington Health)
- **Northwest Washington Medical Bureau** (previously-named Skagit County Medical Bureau)

Tabulations were compiled but not tested for statistical significance, so that caution should be used when comparing the differences seen in coverage rates.

The numbers of individual enrollees receiving each service were directly tabulated, as all plans provided a total enrollee figure. Since not all plans were able to provide a gender breakdown, the aggregate survey population rate of 47% male and 52% female was applied in each section to determine approximate numbers of relevant enrollees by gender. Some services apply only to females and or males of reproductive age, assumed here to be 15 - 44 years. Washington State census projections as of April 1998[12] were used to estimate the percent of "hypothetically eligible" females or males in defined age ranges who are most likely to utilize the service. (This approach assumes that the age distribution of the general population is comparable to that in the usual health insurance plan population.) These percentages were applied as a weighted average to the number of total enrollees receiving services in each category as follows:

| | | |
|---|---|---|
| - | Gynecologic: | females ages 15 – 44 = .4359 |
| - | Maternity: | females ages 15 – 44 = .4359 |
| - | Termination: | females ages 15 – 44 = .4359 |
| - | Infertility: | females and males ages 15 – 44 = .4456 |
| - | Cancer Screening: | females and males ages 15+ = .77509 |
| - | STDs: | females and males ages 15+ = .77509 |
| - | HIV: | females and males ages 15+ = .77509 |
| - | Sterilization: | females and males ages 15 - 44 = .44559 |

Comparisons of OIC survey data with the Alan Guttmacher Institute national survey data were made in consultation with AGI staff [a] and use an average figure for the indemnity plans in the AGI study.

## Survey Sample Description

A total of 91 plans are represented among the 16 original carrier respondents. These plans serve a variety of markets: 48% large group (n = 44), 26% individual (n = 24), 16% small and large group (n = 15), and 9% small group (n = 8). By carrier license, these plans are health care service contractors (66% of plans surveyed), health maintenance organizations (28%), or insurance companies selling indemnity products (6%). This purposive sample is closely representative of the proportions of health plan types in the statewide market (60% HCSC, 35% HMO, 5.4% indemnity).

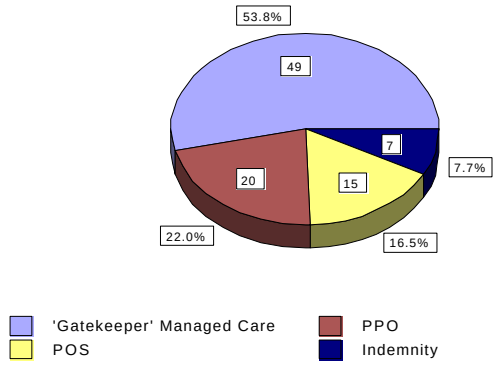
Plans are further categorized by their organizational structure, as to whether they utilize a primary care 'gate-keeper' form of managed care[b] (54% of plans described, n = 49), preferred provider / PPO[a]

[a] Personal communication, AK with R. Gold, study author and J. Darroch, VP for Research, AGI, New York.

[b] In these plans enrollees must use a Primary Care Provider (PCP) for specialty referrals, using contracted providers. Coverage/coinsurance levels are usually based on whether provider is in network; in some plans if an out-of-network

(22%, n = 20), point-of-service / POS[b] (16%, n = 15), or indemnity[c] (8%, n = 7) model of allowing consumers to access health care providers (see Figure 2).

**Fig. 2: OIC Survey Plans, By Type**




The number of enrollees in the specific plans described in the survey is 1,399,650 with a gender breakdown of 48% male and 52% female.[d] This represents one in four Washington State residents, or nearly half (44%) of those with employer-based[e], government-sponsored, or individual health insurance ("covered lives"). Of the nearly 1.4 million enrollees in the surveyed plans, 70% (n = 980,784) are in 'gatekeeper' managed care, 17% (n = 242,260) in PPO, 9% (n = 127,379) in POS, and 4% (n = 49,227) in indemnity-type plans.

The key findings of the survey are outlined on the following pages.[f] Unless otherwise indicated**, data are reported as a <u>combined</u> figure** that includes whether the service is covered routinely ("yes", without restrictions) and/or covered with restrictions. The term "coverage" therefore is used throughout the document to refer to coverage of any kind, i.e., <u>"yes" *plus* "restricted"</u> survey responses.

Figures refer only to the plans surveyed and cannot be assumed to represent all Washington State health insurance plans.

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provider is used there is no coverage.

[a] A "PPO" is a health care arrangement that provides enrollees incentives (such as lower deductibles and copays) to use providers within the network. Enrollees may use non-preferred providers but at a higher cost.

[b] "POS" plans encourage, but do not require, enrollees to choose a primary care provider; plan members may opt to visit non-network providers but must pay higher deductibles and copays than for using network clinicians.

[c] "Indemnity" plans traditionally reimburse the policyholder for health care costs incurred.

[d] This number excludes an additional 20,339 spouses and 122,793 dependents who were listed by some plans. However, not every plan was able to provide this breakout, so only enrollees are reported.

[e] Excludes employer self-funded (ERISA) plans.

[f] Plans are reported by structural definition – that is, whether they are managed care, POS, PPO, or indemnity.

# KEY FINDINGS BY SERVICE CATEGORY

## Routine Gynecological Care

This section of the survey asked about coverage for an annual exam, cancer screening (Papanicolaou smear for cervical cancer, clinical breast exam and mammography for breast cancer), relevant cultures (chlamydia), and sexual health counseling.

Based on national guidelines including the US Preventive Services Task Force[13] and provider responses, minimum[a] "core" services were considered to include Pap smear screening, chlamydia screening, mammography, clinical breast exam, and an annual exam.

### *Background*

Annual exams are useful since gynecological problems are common among women of reproductive age, with more than 4.5 million women aged 18 to 50 reporting at least one chronic gynecological condition each year.[14]

National guidelines recommend screening for reproductive cancers including breast and cervical cancer because survival can be improved with early detection and treatment.

RCW 48.44.325, passed in 1990, requires that health insurance carriers provide benefits for screening or diagnostic mammography services. In Washington State 75% of women over the age of 50, and 72% of women over the age of 40, had mammography in 1993[15] and 64% had both a mammogram and a clinical breast exam within the previous two years.[16] Eighty-seven percent of Washington women had a Pap smear that year. Comparable national figures are 62% for mammography and 85% for Pap smears.[17] Looking at plan performance rather than individual utilization, the national average for both mammography and cervical screening for over 300 health plans that submit data to the National Center for Quality Assurance (NCQA) was around 70% in 1997.[18]

Breast cancer is the second leading cause of cancer death among women; nationally, one in eight women will be diagnosed with breast cancer in her lifetime. The breast cancer death rate in the US was 20.5 per 100,000 females (1996); in Washington the rate was 22.9 per 100,000 in 1994. The national cervical cancer death rate was 2.5 per 100,000 females (1995); in Washington the rate was 2.3 per 100,00 in 1994.[19]

Chlamydia, which is the most common sexually transmitted disease (STD) and a significant cause of infertility, has a prevalence of over 5% among females aged 15 to 19 in the US.[20] Washington's chlamydia case rate was 198 per 100,000 in 1994.[21] Given its significance as a reproductive health indicator, the NCQA has included the routine screening for chlamydia in all sexually active women under the age of 25 in its latest version of the Health Plan Employer Data and Information Set (HEDIS 3.0).[22]

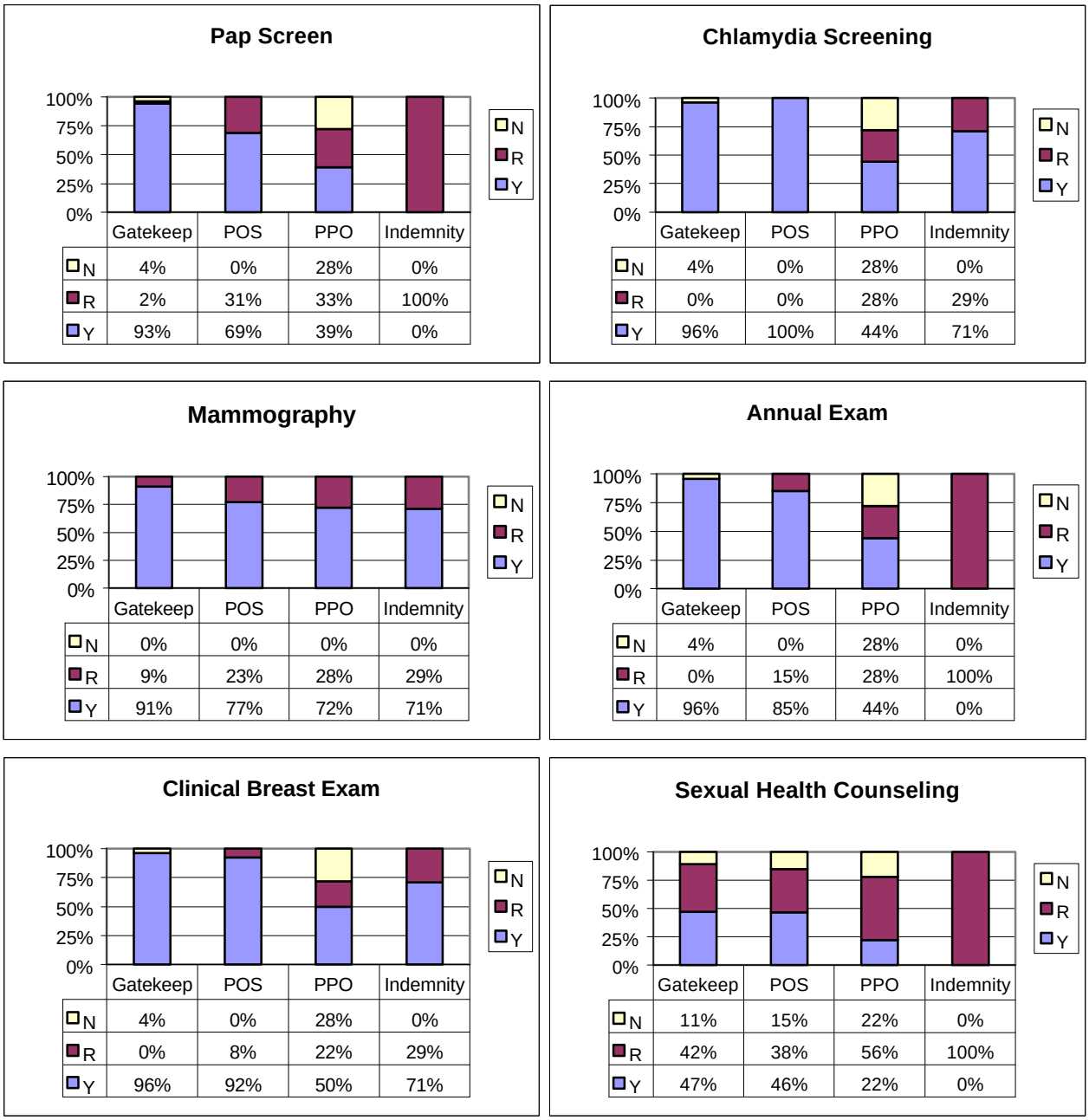
[a] I.e., those services for which there is most consensus among professional groups as well as usual practice or common standard of care. This may not be the optimum or most comprehensive package of services in all cases.

The Institute of Medicine recommends that health counseling related to gynecological and sexual concerns be provided more often by clinicians[23] as a way to improve sexual health functioning and reduce the rates of STDs.

### *Survey Findings*

Please see Figure G-1 for a visual overview of reported service coverage in each plan type, by whether it is covered routinely ('Y'), on a restricted basis ('R'), or not at all ('N').

**Figure G-1: Gynecologic Service Coverage, By Plan Type**



**Total Coverage (Routine plus Restricted Responses)**

Pap smears, chlamydia screening, and clinical breast exams are covered at a range of 72% (PPO) to 100% (POS plans). All plans cover mammography at 100% rate. Sexual health counseling is covered as a separate service at a rate of 78% (PPO) to 100% (indemnity plans).

Eight of the twelve carriers reported that every surveyed plan they offer covers all the services defined as "core" (i.e., Pap smear, chlamydia screening, mammography, clinical breast exam, and an annual exam). Ninety-two percent of plans (n = 76/83) cover these core services: 72% of PPO plans, 96% of 'gatekeeper' plans, and 100% of indemnity and POS plans.

A total of 584,952 female enrollees have coverage for these core services, of whom 254,980 are estimated to be ages 15 – 44. This number represents 81% of all hypothetically eligible[a] females ages 15 – 44 in the total plan enrollment of 314,700 women in this age group. Approximately 28% of eligible females in PPO plans, 91% in 'gatekeeper' plans, 100% in POS plans, and 100% in indemnity plans have coverage for these core services.

**Restrictions**

The gynecologic coverage restrictions described by carriers generally had to do with guidelines relating to frequency and age recommendations. For example many carriers have their own, or utilize national, guidelines for mammography screening. Others cover a Pap smear on an every one to two year basis; some allow a woman to self-refer for additional services as needed. Other restrictions are related to an overall wellness benefit limit, which in some cases is $200 – 250 per year. Several plans provide preventive services only if that optional benefit is selected.

**Rider / Age Restrictions / Direct Access / Copayment**

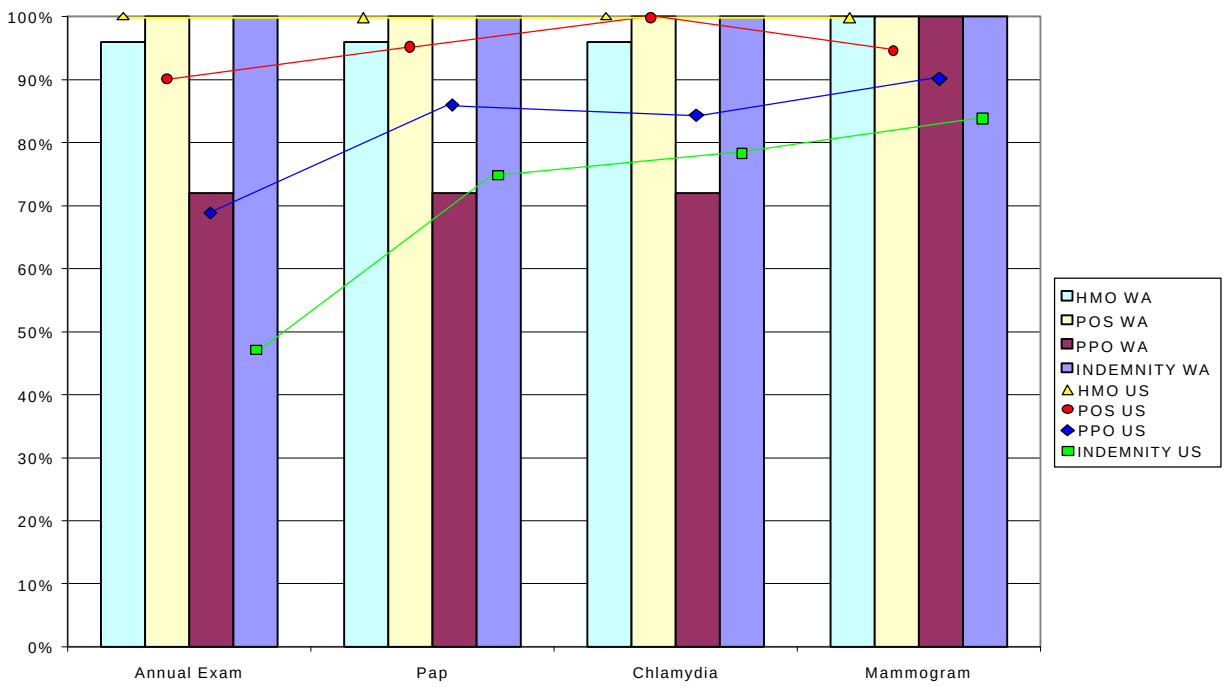
Almost all plans (n = 78/83) that cover these services do so as part of the basic benefit rather than as a separate option or rider. In those plans that offer these services as a rider, the carriers estimate that an average of 78% of enrollees have the benefit. One POS plan has an age restriction in place (i.e., gynecological exam covered every two years for 7 - 20 year olds). All plans reported that they allow women to directly access these services, as is required by law. Most plans apply standard copayments, though around one in five PPO (17%), 'gatekeeper' (22%), and POS (23%) plans, and 86% of indemnity plans, do not require copays or coinsurance / deductibles for gynecologic services.

**National Comparison**

The surveyed plans closely match or exceed the average national coverage seen in 1996 (Figure G-2). Indemnity plans cover gynecologic services at a higher rate than that seen nationally, while other plan type coverage is comparable.

[a] Weighted averages using census data were applied to ensure that the estimates represent the 15 – 44 year old female age distribution in Washington.

**Figure G-2: Gynecologic Coverage By Plan Type, Washington and US 1998**




### *Major Findings*

Despite the high number of plans offering gynecologic service coverage, an estimated one in five women ages 15 – 44 enrolled in these plans do not have coverage for surveyed "core" gynecological services. Coverage rates are lowest for PPO plans.

# Maternity Services

This section of the survey asked about coverage for preconception counseling and screening, diagnosis of congenital disorders of the fetus, prenatal care (including coverage for complications of pregnancy), delivery in hospital, home, or birth unit settings, postpartum care, and well baby services.

Based on national guidelines[24] including the US Preventive Services Task Force and provider responses, minimum "core" services were considered to include prenatal testing and care, hospital delivery, postpartum, and newborn care.

### *Background*

Maternity services are needed by all women of reproductive age (usually defined as ages 15 - 44 years) who are seeking to, or may become, pregnant.

Preconceptual care to facilitate alcohol and smoking cessation, folic acid supplementation, weight gain where appropriate, and other risk assessments and interventions has been shown to reinforce efforts to promote healthy, planned pregnancies.[25] Access to prenatal care – ideally, in the first trimester – is considered critical to optimize maternal and infant outcomes; for this reason, the US Public Health Service has a goal nationally for 90% of pregnant women to access care in the first trimester.[26] In 1993, only 78% of women in the US achieved this target; in Washington the 1995 rate was 83%.[27]

Deliveries can occur in a variety of settings, usually in a hospital or freestanding birth unit[a], or in the home. Care of the woman in the postpartum period and for the newborn are key components of overall maternity services.

While pregnant women of all ages can benefit from maternity services, particular concern has been raised regarding pregnancies among adolescents. Every year in the US approximately half a million teens give birth, many of whom are unprepared for the challenges of parenthood. In recent years teen pregnancy rates have diminished in the US and in Washington. The national rate in 1995 was 56.8 per 1000 women ages 15 -19, and in Washington was 47.5 per 1000.[28]

Given the consensus regarding the importance of maternity care, legislators have mandated that benefits be offered in some cases. In 1978 Title VII of the federal Civil Rights Act of 1964 was amended by the Pregnancy Discrimination Act (PDA) to prohibit discrimination in employment on the basis of pregnancy, childbirth and related conditions and to require that employers with 15 or more employees provide maternity benefits. Washington State requires that employers with eight or more employees provide coverage for pregnancy care and pregnancy termination, and these insurance benefits "must be equal for male and female employees".[29]

In the 1998 legislative session, Senate Bill 6522 "Maternity Services Mandated Benefits" was introduced. This bill would require that Washington health insurance plans cover maternity stays in

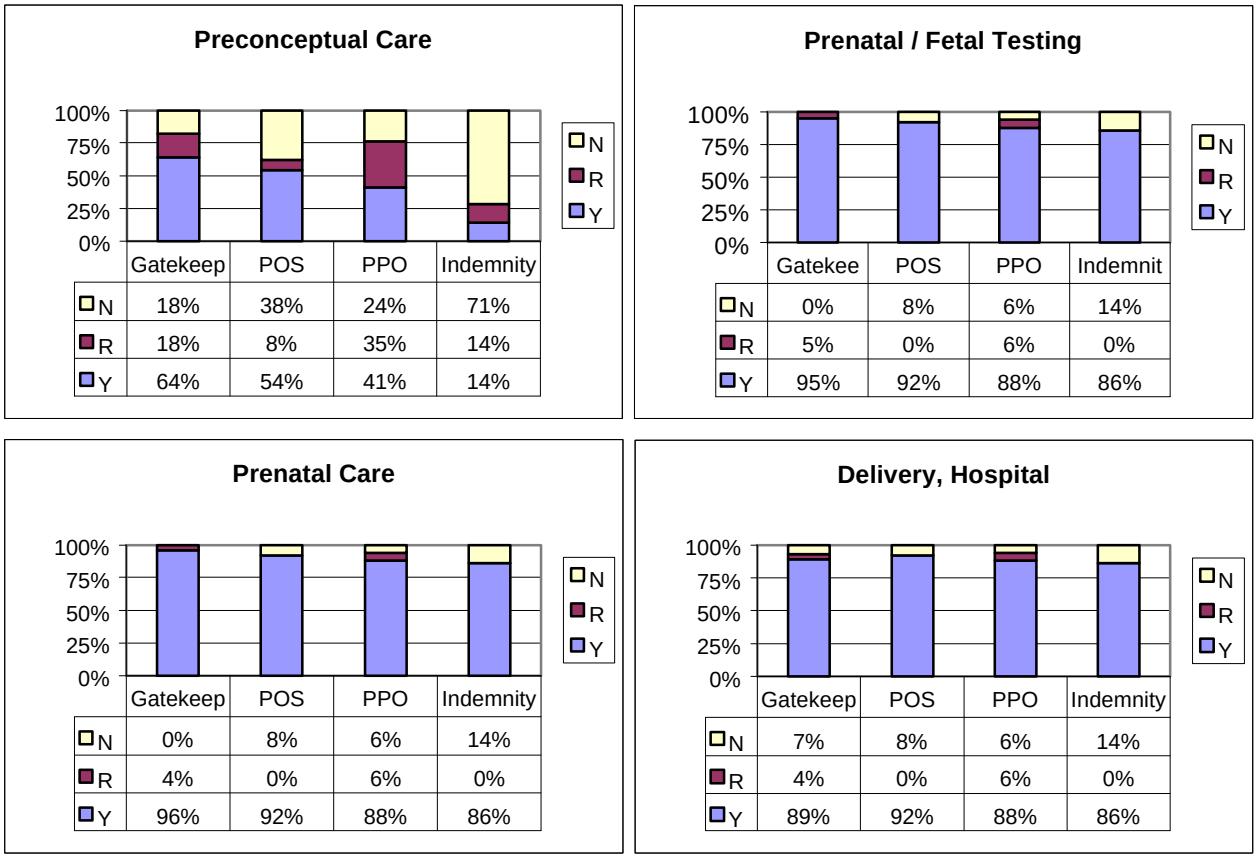
[a] A birth unit is a free-standing facility for delivery of normal pregnancies; all have back-up arrangements with hospitals for transfer of any deliveries that require surgical intervention or pediatric specialists.

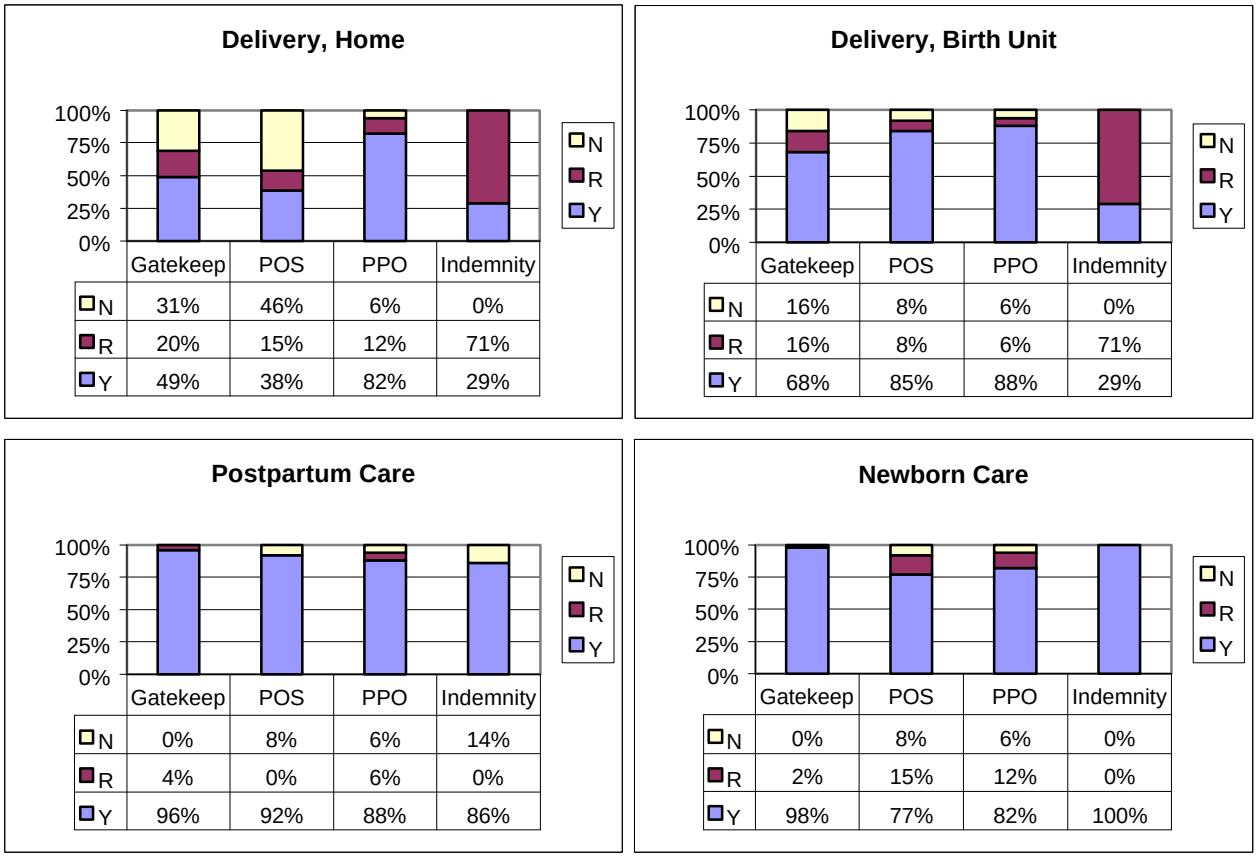
the hospital if they cover other hospitalizations. The bill is presently undergoing "sunrise review" by the Department of Health to answer several statutorially-mandated questions including determining the effect if this service is not provided; how the statute's implementation would impact insurance coverage costs; the percent of consumers who would benefit from this service; the difference in cost between covering and not covering the services; the extent to which insurers now cover maternity services; whether consumers have shown a demand for these services; what type of health plans are most relevant; and to define precisely what “maternity services' entail.[30]

### *Survey Findings*

Please see Figure M-1 for a visual overview of reported service coverage in each plan type, by whether it is covered routinely (‘Y’), on a restricted basis (‘R’), or not at all (‘N’).

**Figure M-1: Maternity Service Coverage, By Plan Type**






**Total Coverage (Routine plus Restricted Responses)**

Preconception counseling is covered from a range of 29% (indemnity) to 82% ('gatekeeper' plans). Home delivery is covered by 54% of POS, 69% of 'gatekeeper', 94% of PPO, and 100% of indemnity plans. Delivery at a birth unit is covered by 84% of 'gatekeeper', 92% of POS, 94% of PPO, and 100% of indemnity plans.

When carriers were asked if their maternity care coverage included coverage of the infant for the first 21 days of life as required by the ERIN Act (RCW 48.43.115), several carriers indicated that they believe they are not obligated to do so unless the child's mother already is eligible for maternity coverage. Half the plans (51%; n = 42) cover the first 21 days for a dependent's newborn.

Prenatal care for teen dependents of enrollees is a covered benefit in 14% of indemnity, 24% of PPO, 31% of POS, and 62% of 'gatekeeper' plans.

All the surveyed plans of nine carriers (75%) cover the core maternity services (i.e., prenatal testing and care, hospital delivery, postpartum and newborn care). About nine out of ten plans (93%; n = 76/82) cover these core services: 86% of indemnity, 92% of POS, 93% of 'gatekeeper', and 94% of PPO plans.

A total of 522,705 females have coverage for these core services, of whom 227,847 are estimated to be ages 15 - 44. This number represents 76% of all hypothetically eligible females ages 15 – 44 in

the total plan enrollment of 300,088 women in this age group. Approximately 64% of eligible females in POS plans, 67% of eligible females in 'gatekeeper' plans, 68% of eligible females in PPO plans, and 100% of eligible females in indemnity plans have coverage for these core services.

**Restrictions**

The service coverage restrictions described by the carriers in this section included overall benefit dollar limits, such as $1,300 for vaginal delivery or $700 maximum for office visits or $500 hospital limits seen in three different individual plans.

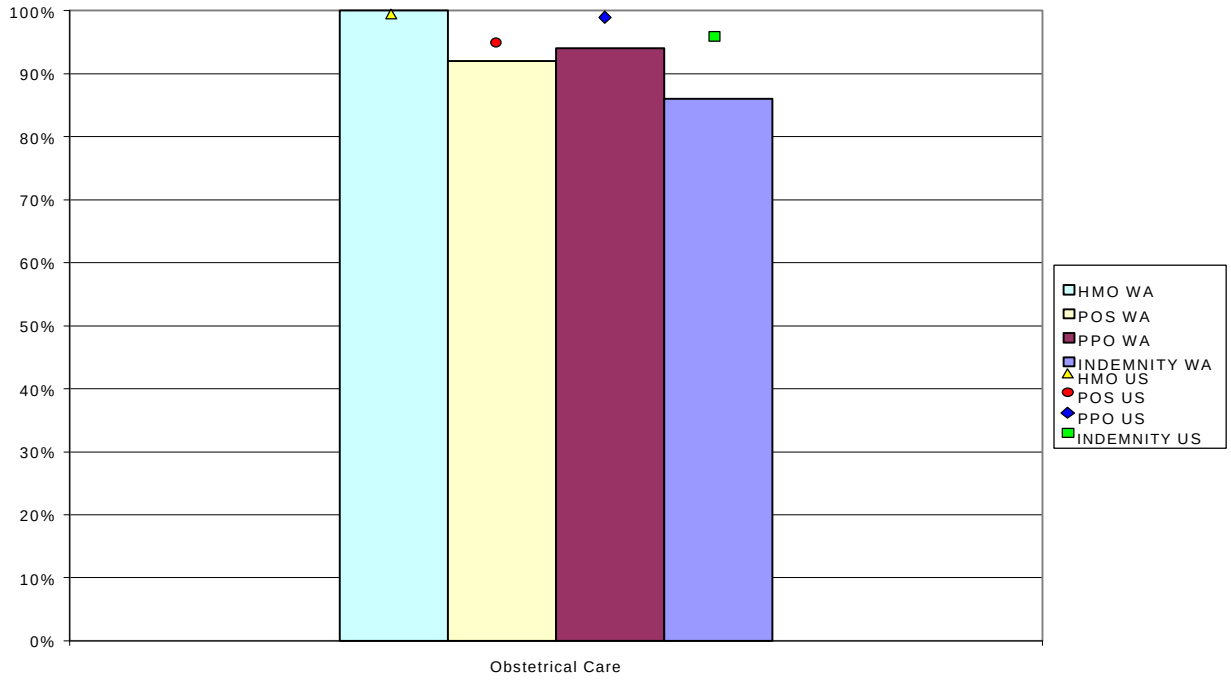
**Rider / Dollar Limits / Direct Access / Wait Period**

Of those plans that cover maternity services, most (n = 76/83) do so as part of the basic benefit rather than as a separately-purchased rider. Three plans (two with Regence and one with Northwest Washington Medical Bureau) are marketed to individuals and do not offer maternity coverage. No plan restricted the number of births payable in a calendar year, nor did any place specific dollar limits on births in a year, though some plans do have specific overall maternity benefit limits. All plans allow a woman to self-refer for care (direct access). Most plans do not impose a wait period, although one carrier (Northwest Washington Medical Bureau) appears to restrict maternity benefit coverage in two of its plans in a manner not allowed by state law.

**National Comparison**

The surveyed plans generally provide coverage at a lower rate than the average national coverage seen in 1996, with the exception of 'gatekeeper' managed care plans which are slightly higher than the national (Figure M-2).

**Figure M-2: Maternity Coverage By Plan Type, Washington and US 1998**



### *Major Findings*

The Maternity Services (Erin Act) RCW 48.43.115 requires that coverage "for the newborn child must be no less than the coverage of the child's mother for no less than three weeks". The survey reveals that there is some variation in interpretation of this requirement, with some plans taking compliance to mean that the enrollee has a certain number of days to enroll the child onto her/his health plan; other carriers taking it to mean that they must provide 21 days of newborn coverage of any teen dependent; and still other carriers reading the statute to mean that they are not required to provide coverage to a newborn unless the mother already is eligible for maternity coverage. Almost all plans offer core maternity services, but several plans with relatively large enrollment do not. Therefore, nearly one in four women don't get this coverage.

## Contraception and Family Planning

This section of the survey asked about coverage for contraceptive counseling, over-the-counter (OTC) contraception, intrauterine devices (IUDs), insertion, and removal, diaphragm and cervical cap devices and fitting, Norplant device, insertion, and removal, Depo-Provera injections, oral contraceptive pills, and emergency contraception (i.e., hormonal contraception usually given within 72 hours of unprotected intercourse to prevent pregnancy).

Based on national guidelines[31] and provider responses, minimum core services were defined as IUDs, diaphragm and Norplant devices, Depo-Provera injections, and oral contraceptive pills.

### *Background*

Contraceptive services and overall health are interconnected. The availability of contraceptives, for example, can help women and men to avoid unwanted pregnancy and sexually-transmitted infections. This in turn can result in fewer abortions and a lower incidence of infertility.

Among American women using contraception, 24 million (61%) use reversible methods such as condoms (used by 20% of contracepting men and women), or birth control pills (used by 27%); the remaining 15 million women users (39%) use either male or female sterilization for contraception.[32] The 10% of American women who are not using contraceptives account for over half of all unplanned pregnancies.[33]

It is estimated that half (49%) of all pregnancies in the US are unintended, and at least 10% of these are unwanted as well. Unintended pregnancy rates in Washington are slightly higher than the national average: between 1993 and 1994, 55% of all pregnancies were unintended at the time of conception.[34] Unintended pregnancies occur most often among persons not using contraception: in a given year 85% of sexually active women not using contraception will become pregnant, whereas the pregnancy failure rates for those using contraceptives range from a low of 0.1% (for one type of IUD) to a high of 36% (for cervical caps), when used under normal/average conditions.[35] Any barriers to contraceptive use, such as an individual having an unusually high copay or to pay out-of-pocket entirely for their contraceptive method, may impede the use of that contraceptive and thus may increase the numbers of unintended pregnancies and/or STDs that occur.[36] Health insurance plans commonly exclude coverage for effective forms of contraception.[37]

In one study comparing the effectiveness and costs per person associated with 15 contraceptive methods over a five-year period, it was found that all methods resulted in savings at the five-year point. The cost of using no method (based on rates of unintended and mistimed pregnancies and STDs) over five years is around $6,800; dollars saved by contraceptive use ranged from $3,500 with the cervical cap to $5,700 with the copper-T IUD.[38] A 1994 study by the Washington State Department of Health found that for every dollar spent on family planning to avoid unintended pregnancy at least seven dollars are saved.[39] Contraceptive services provided through public clinics cost $150 per client as compared to $4750 for publicly-financed prenatal, labor, and delivery costs.[40]

Although most employer-sponsored health plans cover prescription drugs, a national survey of health carriers conducted in 1996 showed that about half (51%) of the large-group plans specifically cover contraceptives.[41] A more recent national probability survey of public and private employer-sponsored

health plans showed that 68% of the HMO and 44% of the indemnity plans cover contraceptive drugs; 49% of HMO and 31% of indemnity plans covered contraceptive devices.[42] Only 15% of health plans nationally cover all five FDA-approved methods of reversible contraception (oral contraceptives, Depo Provera, Norplant, IUD, and the diaphragm) – all of which are used exclusively by women.[43]

Because many contraceptive drugs and devices are used only by women, non-coverage of contraceptives by health plans has been perceived as a gender equity / civil rights issue.[44] At the federal level, an "Equity in Prescription Insurance and Contraceptive Coverage Act" was introduced in Congress in 1997 that if passed would mandate that insurance carriers cover contraceptives. In July 1998 both the House and the Senate approved provisions that would require coverage of contraceptives for all 2.4 million Federal employees.[45]

In the 1998 Washington legislative session, House Bill 2594 was introduced with the intent of reducing the number of unintended pregnancies and increasing equity in coverage of prescription drugs and devices. The bill would have mandated coverage of contraceptive services and supplies in health plans that cover prescriptions and similar outpatient services, requiring insurers to pay for contraceptives to the extent that they pay for other prescriptive services.[46] This bill is currently under sunrise review by the Department of Health to determine its cost-effectiveness and other likely impact if enacted.

While most family planning methods provide protection against pregnancy, a relative few have been shown to also protect against STDs. Since the advent of the HIV/AIDS epidemic, the Centers for Disease Control and Prevention (CDC) recommends that all sexually active persons use latex condoms for the prevention of HIV and other STDs. Many providers now routinely recommend dual method use, i.e., that their patients use condoms and another method for preventing pregnancy.[47]

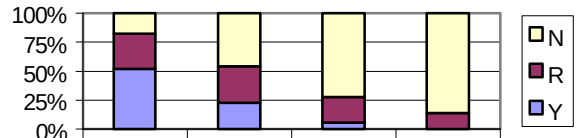
Patient counseling regarding sexual health issues is recommended by professional associations, [48, 49] national health organizations, and federal health agencies such as the Institute of Medicine. However, national data show that one in three (35%) obstetrician-gynecologists and two out of three pediatricians (64%) do not discuss family planning with their patients.[50]

### *Survey Findings*

Please see Figure C-1 for a visual overview of reported service coverage in each plan type, by whether it is covered routinely ('Y'), on a restricted basis ('R'), or not at all ('N').

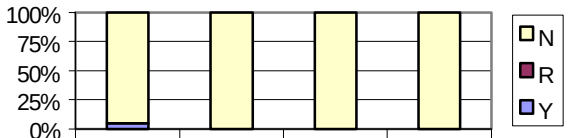
**Figure C-1: Contraception Service Coverage, By Plan Type**

### Contraceptive Counseling



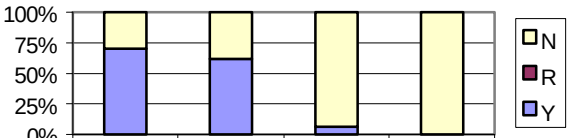

| | Gatekeep | POS | PPO | Indemnity |
|---|---|---|---|---|
| N | 18% | 46% | 72% | 86% |
| R | 30% | 31% | 22% | 14% |
| Y | 52% | 23% | 6% | 0% |

### OTC Contraception



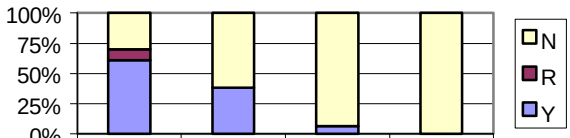

| | Gatekeep | POS | PPO | Indemnity |
|---|---|---|---|---|
| N | 95% | 100% | 100% | 100% |
| R | 0% | 0% | 0% | 0% |
| Y | 5% | 0% | 0% | 0% |

### IUD



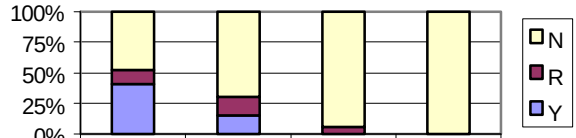

| | Gatekeep | POS | PPO | Indemnity |
|---|---|---|---|---|
| N | 30% | 38% | 94% | 100% |
| R | 0% | 0% | 0% | 0% |
| Y | 70% | 62% | 6% | 0% |

### Diaphragm



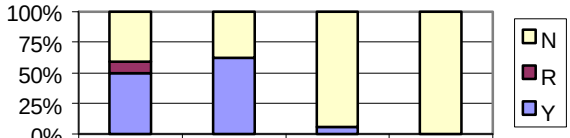

| | Gatekeep | POS | PPO | Indemnity |
|---|---|---|---|---|
| N | 30% | 62% | 94% | 100% |
| R | 9% | 0% | 0% | 0% |
| Y | 61% | 38% | 6% | 0% |

### Norplant



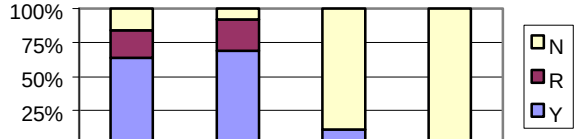

| | Gatekeep | POS | PPO | Indemnity |
|---|---|---|---|---|
| N | 48% | 69% | 94% | 100% |
| R | 11% | 15% | 6% | 0% |
| Y | 41% | 15% | 0% | 0% |

### Depo-Provera



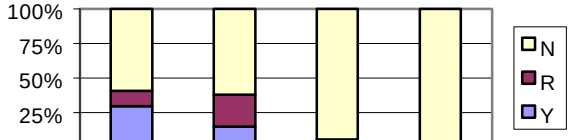

| | Gatekeep | POS | PPO | Indemnity |
|---|---|---|---|---|
| N | 41% | 38% | 94% | 100% |
| R | 9% | 0% | 0% | 0% |
| Y | 50% | 62% | 6% | 0% |

### OCPs




| | Gatekeep | POS | PPO | Indemnity |
|---|---|---|---|---|
| N | 16% | 8% | 89% | 100% |
| R | 20% | 23% | 0% | 0% |
| Y | 64% | 69% | 11% | 0% |

### Emergency Contraception




| | Gatekeep | POS | PPO | Indemnity |
|---|---|---|---|---|
| N | 59% | 62% | 94% | 100% |
| R | 11% | 23% | 0% | 0% |
| Y | 30% | 15% | 6% | 0% |

**Total Coverage (Routine plus Restricted Responses)**

Half (50%) of the plans cover contraceptive services in some form. Thirty percent of all plans cover the five FDA-approved reversible methods of contraception – IUD, diaphragm, Norplant, Depo Provera, and oral contraceptives – that are used exclusively by women.

Very few plans cover over-the-counter contraceptive devices such as male[a] and female condoms and spermicides. Despite the CDC recommendation that all sexually active individuals use condoms with or without spermicides, only two plans cover over-the-counter contraceptives: Aetna's Basic Health Plan, which covers OTCs for teen enrollees ages 12 - 17 as a social policy choice, and Community Health Plan's Healthy Options plan (Medicaid contract).

Approximately two in three POS (62%), and 'gatekeeper' (70%) plans, and very few indemnity (0%) and PPO (6%) plans cover IUDs; similar rates are seen with diaphragm availability (except that POS plans cover at only 38%). Higher than standard copays sometimes are charged for IUDs.

Carriers frequently exclude hormonal implants (Norplant). This is covered at a rate of 0% by indemnity, 6% by PPO, 31% by POS, and 52% by 'gatekeeper' plans. Hormonal injections (Depo-Provera) are covered at a rate of 0% by indemnity, 6% by PPO, 59% by 'gatekeeper', and 62% by POS plans. Copays generally are charged on a monthly basis for Norplant and DPMA. Oral contraceptives and other contraceptive drugs are usually part of a prescription drug program, and are typically available when a prescription drug benefit is purchased. Oral contraceptive coverage is available in zero indemnity plans, 11% of PPO, 84% of 'gatekeeper', and 92% of POS plans. Emergency (post-coital) contraception is not yet widely available in most health plans: zero indemnity plans, and only 6% of PPO, 38% of POS, and 41% of 'gatekeeper' plans cover this service.

Only one carrier's entire list of surveyed plans (Community Health Plan) covers all the core services (i.e., IUDs, diaphragm and Norplant devices, Depo-Provera injections, and oral contraceptive pills). Thirty percent of all plans (n = 25/82) cover the core contraceptive services: zero indemnity plans, 6% of PPO, 15% of POS, and 50% of 'gatekeeper' plans.

A total of 148,587 female enrollees have coverage for these core services, of whom 64,769 are estimated to be 15 – 44. This number represents around 22% of all hypothetically eligible females ages 15 - 44 in the total plan enrollment of 298,003 women in this age group. Approximately 0% of eligible women in indemnity plans, 1% in POS plans, 3% in PPO plans, and 29% in 'gatekeeper' plans have coverage for these core services.

**Restrictions**

The service coverage restrictions described by the carriers in this section included higher than standard office visit or pharmacy copays (e.g., $100 for Norplant); coverage for insertion or removal but not the contraceptive device itself; or coverage only for certain methods such as OCPs – which often are covered only if a prescriptive drug benefit has been purchased.

[a] Male contraceptives other than the condom are not yet FDA-approved; because condoms do not require a prescription, health plans rarely pay for them.

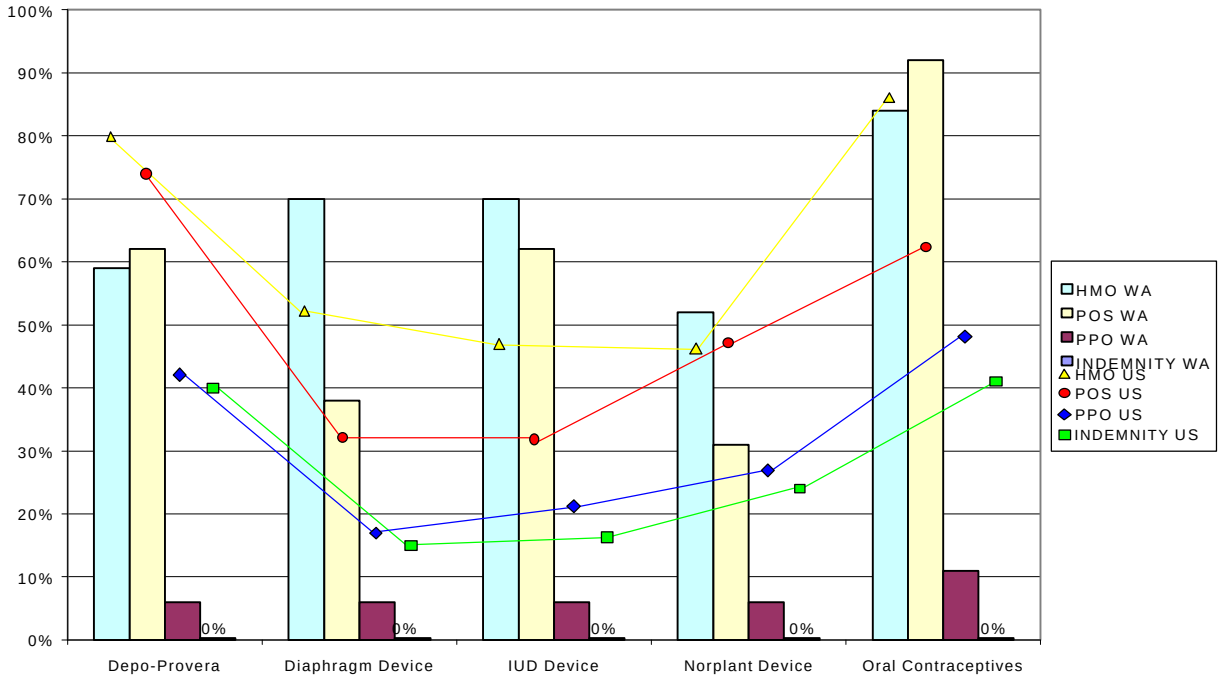
**Rider / Direct Access / Copayment**

Fourteen percent of indemnity, 27% of 'gatekeeper', 39% of PPO, and 54% of POS plans offer contraceptive coverage as an optional rider. Of those plans that offer these services only as an option, the carriers estimate that 51% of enrollees (or their employers) have purchased the rider.

**National Comparison**

Surveyed 'gatekeeper' and PPO plans provide core coverage at a generally higher rate than the average national coverage seen in 1996, but indemnity and PPO plan coverage is significantly lower than the national (Figure C-2).

**Figure C-2: Contraception Coverage By Plan Type, Washington and US 1998**




## *Major Findings*

Fully half (50%) of the plans do not cover contraceptive services at all. This study found that fewer than one in three surveyed plans routinely cover all 5 FDA-approved reversible methods of contraception. While this is higher than national average of 15% in 1996, it is still troublesome. Some 78% of women who could be eligible are *not* receiving contraceptive coverage through their health plan, as recommended by the Institute of Medicine, among others.

Counseling for sexual health concerns may not be readily available, since most plans will not reimburse the provider for the counseling as a separate service, but only as part of an office visit or as a mental health visit. Since many primary care and obstetrical-gynecological providers generally do not see themselves as providing mental health, this service may be underutilized.

# Termination of Pregnancy

This section of the survey asked about coverage for elective and medically necessary termination of pregnancy.

Both elective and medically necessary terminations were defined as the core services.

### *Background*

The rate of pregnancy termination in Washington has been declining steadily, from 31.6 per 1000 women ages 15 - 44 in 1980, to 20.7 in 1995. Nationally, the number of reported abortions per 1000 women 15 - 44 years old declined by 8% between 1980 and 1992.[51] While US teens have higher abortion rates than among all women 15 - 44, the rate among teens in Washington had dropped to 20.9 per 1000 in 1995, comparable to the rate for all women.[52]

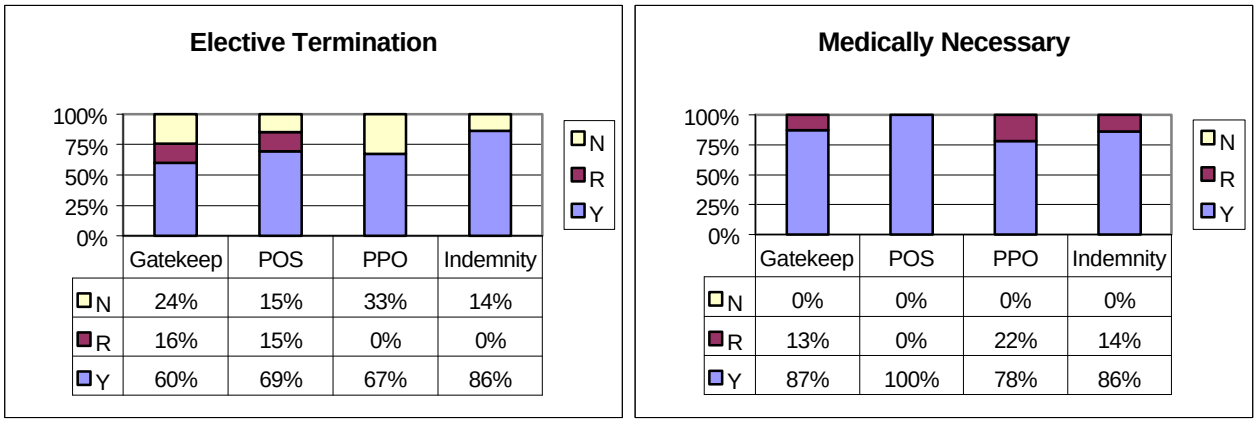
In 1991 the voters in Washington passed Initiative 120, the Reproductive Privacy Act, RCW 9.02, stating that "[e]very woman has the fundamental right to choose or refuse to have an abortion...[and that] the state shall not deny or interfere with a woman's fundamental right to choose or refuse to have an abortion."

The Conscience Clause ensures that carriers, facilities, and individual clinicians with a religious or moral tenent opposed to a specific service cannot be required to purchase coverage for that service.[53]

### *Survey Findings*

Please see Figure T-1 for a visual overview of reported service coverage in each plan type, by whether it is covered routinely ('Y'), on a restricted basis ('R'), or not at all ('N').

**Figure T-1: Pregnancy Termination Service Coverage, By Plan Type**




| | Gatekeep | POS | PPO | Indemnity |
|---|---|---|---|---|
| N | 24% | 15% | 33% | 14% |
| R | 16% | 15% | 0% | 0% |
| Y | 60% | 69% | 67% | 86% |

| | Gatekeep | POS | PPO | Indemnity |
|---|---|---|---|---|
| N | 0% | 0% | 0% | 0% |
| R | 13% | 0% | 22% | 14% |
| Y | 87% | 100% | 78% | 86% |

**Total Coverage (Routine plus Restricted Responses)**

All plans cover medically necessary procedures. Sixty-seven percent of PPO, 76% of 'gatekeeper', 85% of POS, and 86% of indemnity plans also cover elective procedures.

All the surveyed plans of six carriers (50%) cover both services. Seventy-seven percent of all plans (n = 63/82) cover core termination services: 67% of PPO, 76% of 'gatekeeper', 85% of POS, and 86% of indemnity plans.

A total of 325,692 female enrollees have coverage for these core services, of whom 141,969 are estimated to be 15- 44. This number represents 45% of all hypothetically eligible females ages 15 – 44 in the total plan enrollment of 314,379 women in this age group. Approximately 14% of eligible females in POS plans, 33% in 'gatekeeper' plans, 48% in PPO plans, and 100% in indemnity plans have coverage for these core services.

**Restrictions**

The service coverage restrictions described by the carriers include a requirement for utilization review authorization for elective termination beyond the first trimester (First Choice Health plans); and coverage availability only when the group purchases the rider.

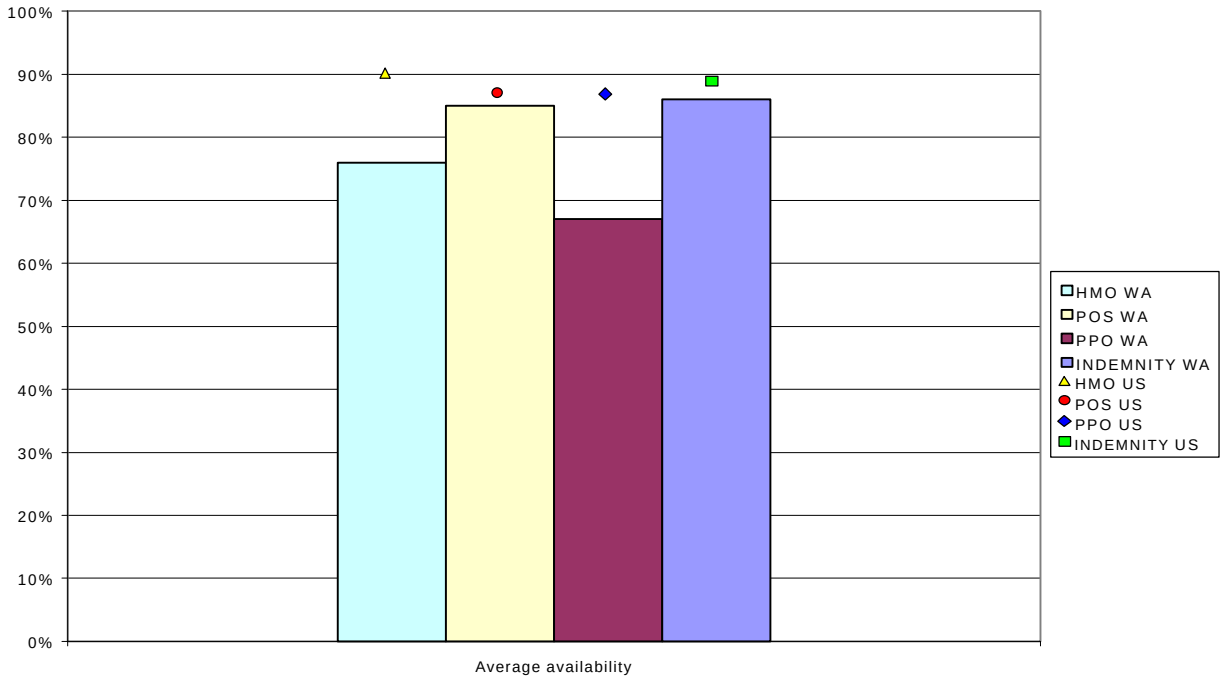
**Rider / Employer Exclusion / Provider Opt Out / Direct Access / Copayment**

Most plans (n = 73/82) that cover this service do so as part of the benefit, not as a separately-purchased option. Of those plans that offer these services only as an option, the carriers estimate that on average 80% of enrollees (or their employers) have purchased the rider. Most carriers allow employers to exclude this benefit from their employee offerings. Carriers also allow individual providers to opt out of performing this service, in accordance with state law. The OIC did not ask respondents to explain whether they require purchasers or providers to meet the criteria of religious or moral tenet requirement. Under the Conscience Clause if a provider "opts out" the enrollee is supposed to receive written information describing how she/he may directly access services in an expeditious manner. In practice, some carriers are themselves providing the referral when a woman calls indicating that her provider refused the procedure. All plans allow women to self-refer for care. Most plans charge standard outpatient/in-patient copays for this service. Coverage in some plans is subject to the overall maternity benefit limits.

**National Comparison**

The surveyed plans provide coverage at an equivalent rate to the national average in the indemnity and POS plans, but at a lower rate than the national average for PPO and 'gatekeeper' managed care plans (Figure T-2).

**Figure T-2: Termination Coverage By Plan Type, Washington and US 1998**




### *Major Findings*

Fifty-five percent of all eligible women enrolled in the surveyed plans do *not* have coverage for both elective and medically necessary procedures. Ironically, pregnancy termination is covered by plans at a higher rate than pregnancy prevention (i.e., contraceptive services).

# Infertility

This section of the survey asked about coverage for infertility diagnosis and treatment, specifically endometrial biopsy, endometriosis treatment, semen analysis, assisted reproductive technologies, and fertility drugs.

Based on national surveys[54] and provider responses, minimum core services were defined to include both infertility diagnosis and treatment.

## *Background*

Infertility is a health issue affecting women and men. The causes of infertility are attributable in approximately one-third of the cases to conditions affecting males, one-third to females, and in one-third of the cases to both.

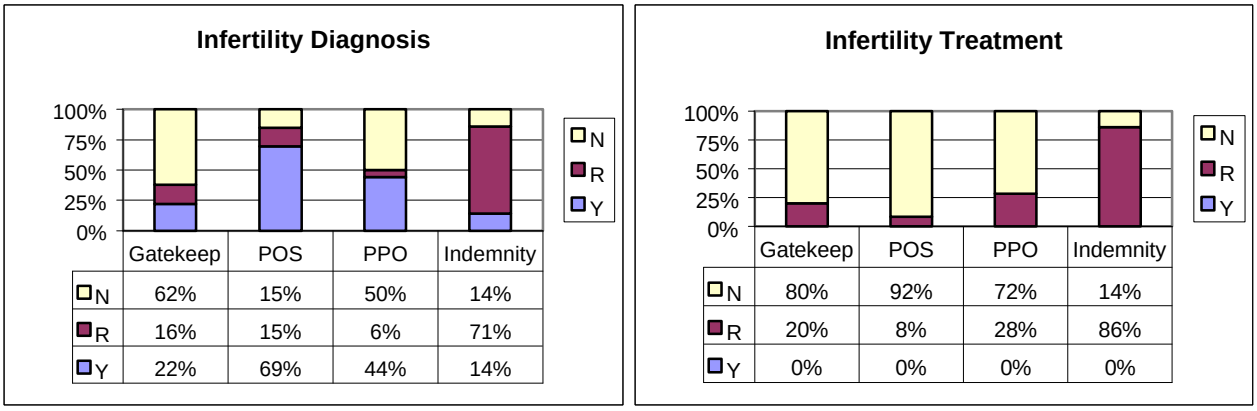
The prevalence of infertility in the US in 1995 was 7.1% (among married couples with wives ages 15 - 44).[55] With women now delaying childbirth until later years (particularly in the baby boom generation), infertility has become a growing health issue, affecting 6.2 million women in 1995.[56]

Technological advances in fertility treatment have been rapid, and costs have grown concurrently. Fertility treatments (surgical and pharmaceutical methods to reverse the causes of infertility) generally are not covered by health plans because of the costs involved and the number of cycles or attempts that couples may require for a chance at a sustained pregnancy. There is increased interest in the issue of infertility coverage, however, because it is becoming recognized that employers are paying for fertility services (presumably billed as other, medically covered treatments) whether they are aware of it or not. In a study soon to be published, it has been concluded that the hidden costs of infertility treatments range from 27 - 50 cents per month for each member of the insurance plan, and that it would cost around 40 - 50 cents per month to provide specific coverage.[57]

## *Survey Findings*

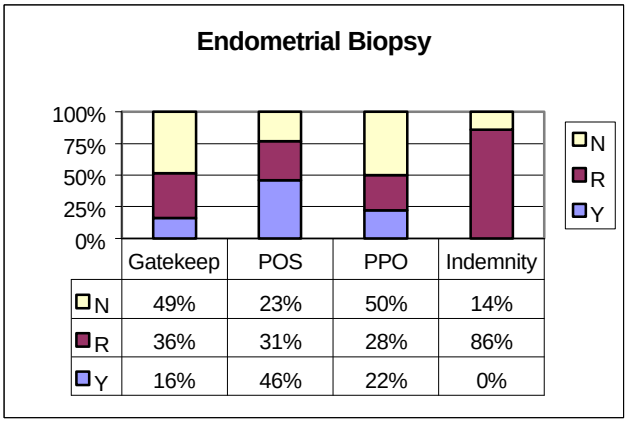
Please see Figure I-1 for a visual overview of reported service coverage in each plan type, by whether it is covered routinely ('Y'), on a restricted basis ('R'), or not at all ('N').

**Figure I-1: Infertility Service Coverage, By Plan Type**

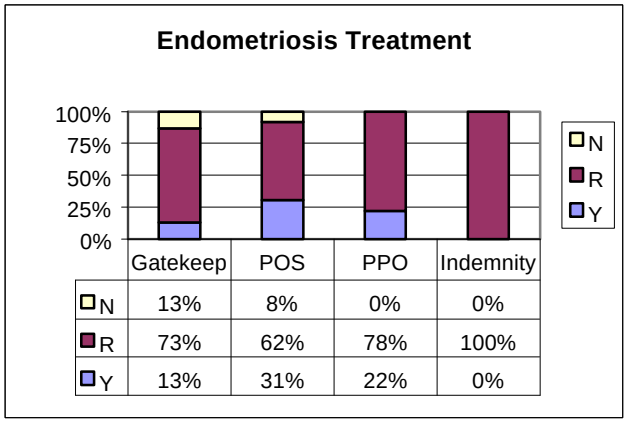



| Infertility Diagnosis | Gatekeep | POS | PPO | Indemnity |
|---|---|---|---|---|
| N | 62% | 15% | 50% | 14% |
| R | 16% | 15% | 6% | 71% |
| Y | 22% | 69% | 44% | 14% |

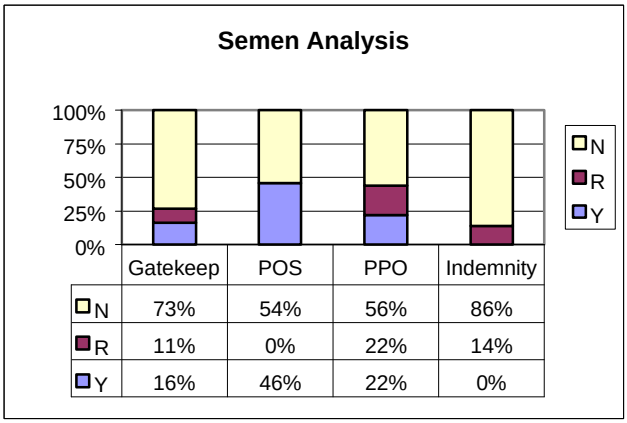
| Infertility Treatment | Gatekeep | POS | PPO | Indemnity |
|---|---|---|---|---|
| N | 80% | 92% | 72% | 14% |
| R | 20% | 8% | 28% | 86% |
| Y | 0% | 0% | 0% | 0% |



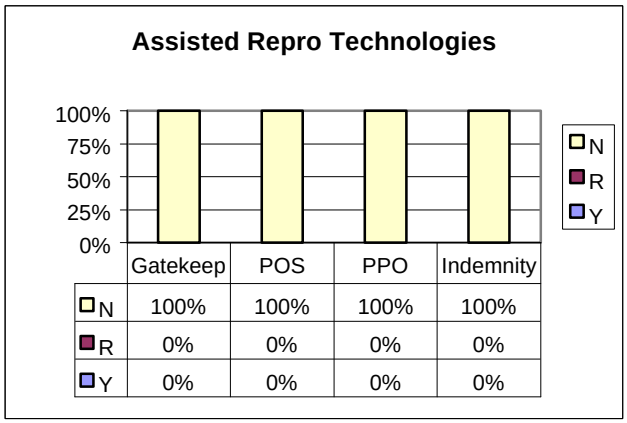

| | Gatekeep | POS | PPO | Indemnity |
|---|---|---|---|---|
| N | 49% | 23% | 50% | 14% |
| R | 36% | 31% | 28% | 86% |
| Y | 16% | 46% | 22% | 0% |



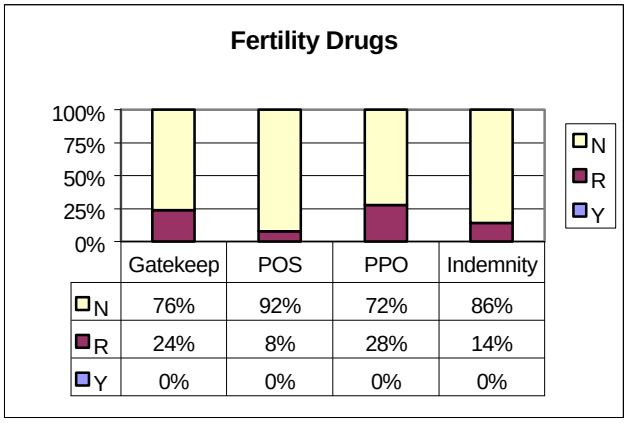

| | Gatekeep | POS | PPO | Indemnity |
|---|---|---|---|---|
| N | 13% | 8% | 0% | 0% |
| R | 73% | 62% | 78% | 100% |
| Y | 13% | 31% | 22% | 0% |




| | Gatekeep | POS | PPO | Indemnity |
|---|---|---|---|---|
| N | 73% | 54% | 56% | 86% |
| R | 11% | 0% | 22% | 14% |
| Y | 16% | 46% | 22% | 0% |




| | Gatekeep | POS | PPO | Indemnity |
|---|---|---|---|---|
| N | 100% | 100% | 100% | 100% |
| R | 0% | 0% | 0% | 0% |
| Y | 0% | 0% | 0% | 0% |




| | Gatekeep | POS | PPO | Indemnity |
|---|---|---|---|---|
| N | 76% | 92% | 72% | 86% |
| R | 24% | 8% | 28% | 14% |
| Y | 0% | 0% | 0% | 0% |

**Total Coverage (Routine plus Restricted Responses)**

These services are among the least covered noted in the survey. While some of the sampled carriers report that they cover the diagnosis of infertility, all exclude the *routine* treatment of infertility. Five carriers do provide *restricted* coverage for infertility treatment, such as paying at a 50% coverage rate. Specific exclusions on assisted reproductive technologies (ART; e.g., in-vitro fertilization) and fertility drugs are common among all carriers. ARTs are not part of any of the surveyed plan benefits.

Some carriers will cover the treatment of specific conditions that contribute to infertility (such as endometriosis), but do so only for treatment of the medical condition itself rather than to reverse infertility.

All the surveyed plans of two carriers (17%) cover on a restricted basis both infertility diagnosis and treatment. Twenty-five percent of all plans (n = 21/83) cover these core services on a restricted basis: 8% of POS, 20% of 'gatekeeper', 28% of PPO, and 86% of indemnity plans.

A total of 16,580 female and male enrollees have coverage for these core services, of whom an estimated 7,388 are ages 15 – 44. This number represents 1.2% of all hypothetically eligible females and males ages 15 – 44 in the total plan enrollment of 618,659 women and men in this age group. Approximately 0.3% of eligible females and males in PPO plans, 0.5% in POS plans, 0.8% in 'gatekeeper' plans, and 15% in indemnity plans have restricted coverage for these core services.

**Restrictions**

The service coverage restrictions described by the carriers most often pertain to endometriosis and endometrial biopsy, which are treated as medical conditions but not to reverse infertility.

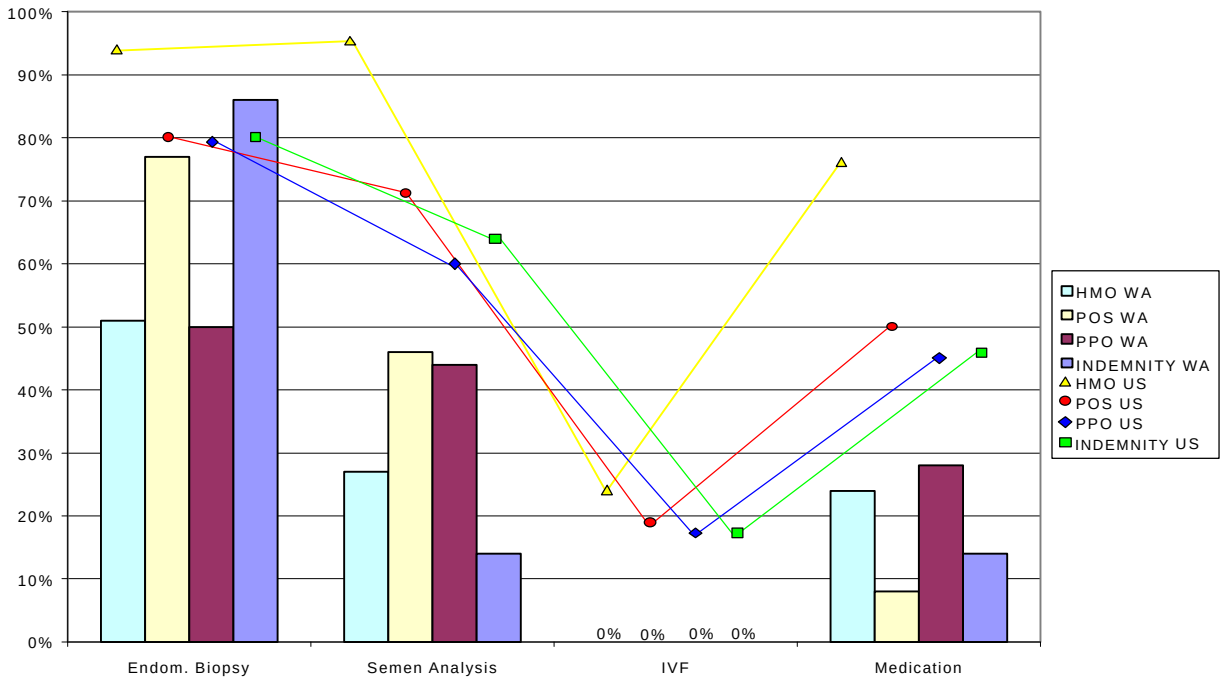
**Rider / Wait Period / Age Restrictions / Direct Access / Copayment**

One in five plans (n = 17/83) offer these services as a rider. Of those plans that offer these services as an option, the carriers estimate that on average 17% of enrollees (or their employers) have purchased the rider. Most plans (n = 73/83) do not impose a wait period, though some do require a diagnosis of infertility as "an inability to get pregnant in over one year". No plans impose an age restriction. Standard copays apply.

**National Comparison**

The surveyed plans tend to cover infertility services at a much lower rate in comparison with national data from 1996. It may well be the case that nationally the market has changed and that many other carriers also tend not to cover infertility services as often as in the past.

**Figure I-2: Infertility Coverage By Plan Type, Washington and US 1998**



### *Major Findings*

Few surveyed plans include infertility treatment as a covered benefit, though given the aging population and delays in childbearing, there is probably a growing market for infertility services in Washington.

# Reproductive Cancer Screening

This section of the survey asked about coverage for prostate, testicular, cervical, and ovarian cancer screening,[a] breast cancer mastectomy, breast cancer lumpectomy, breast reconstruction, and post-operative physical therapy rehabilitation.

Based on national guidelines[58] and provider responses, minimum core services were defined as prostate, testicular, cervical, and ovarian cancer screening.

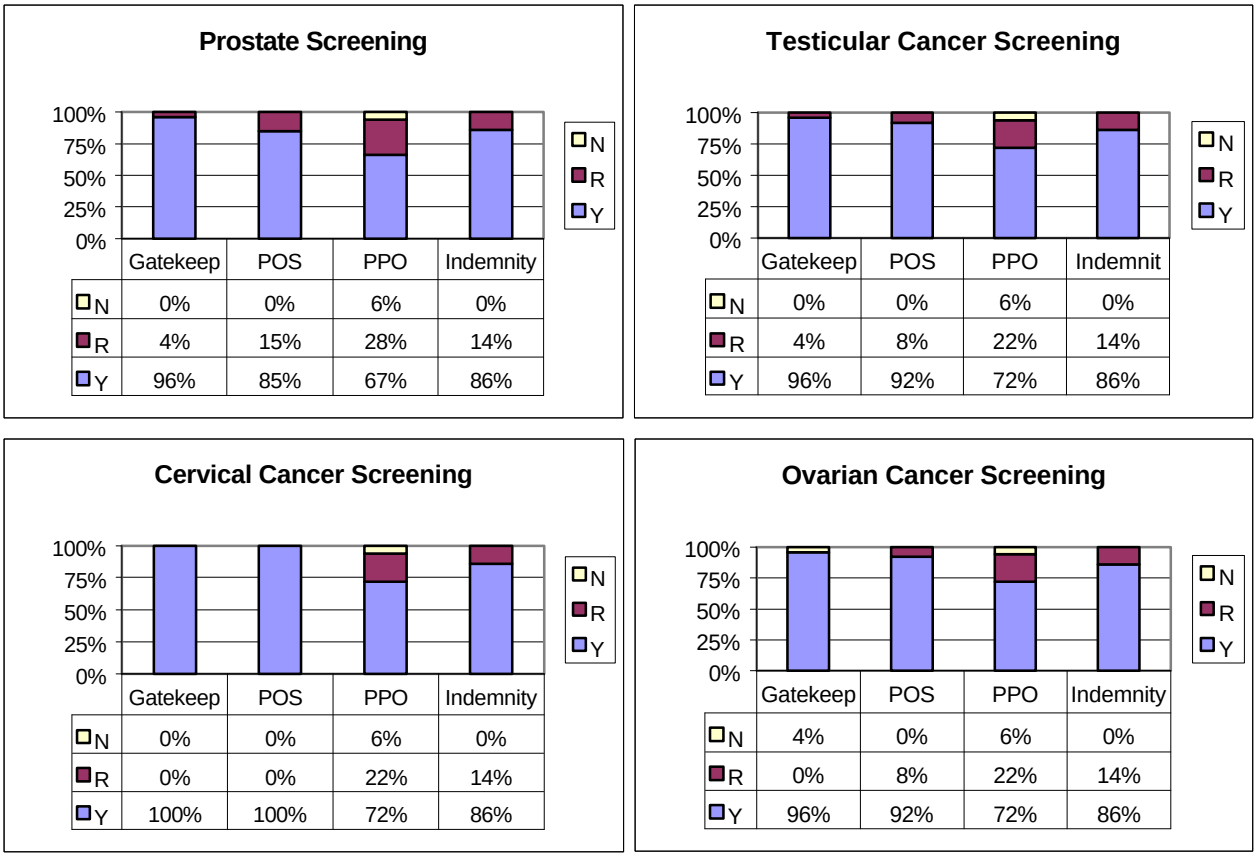
### *Background*

Cervical cancer is 99% curable when found in the earliest stage, and death rates due to this cancer have dropped by 75% over the last 40 years due to increased Pap screening. Cervical cancer mortality was 2.3 per 100,000 females in 1994.[59] Prostate cancer screening in King County is routinely performed by 83% of physicians.[60]

### *Survey Findings*

Please see Figure C-1 for a visual overview of reported service coverage in each plan type, by whether it is covered routinely ('Y'), on a restricted basis ('R'), or not at all ('N').

**Figure C-1: Reproductive Cancer Service Coverage, By Plan Type**



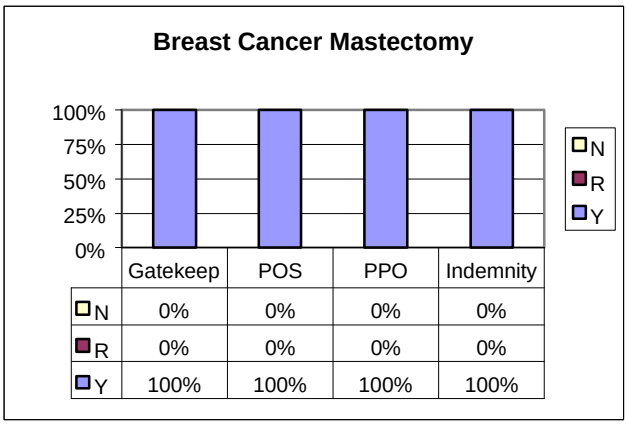

| Prostate Screening | Gatekeep | POS | PPO | Indemnity |
|---|---|---|---|---|
| N | 0% | 0% | 6% | 0% |
| R | 4% | 15% | 28% | 14% |
| Y | 96% | 85% | 67% | 86% |

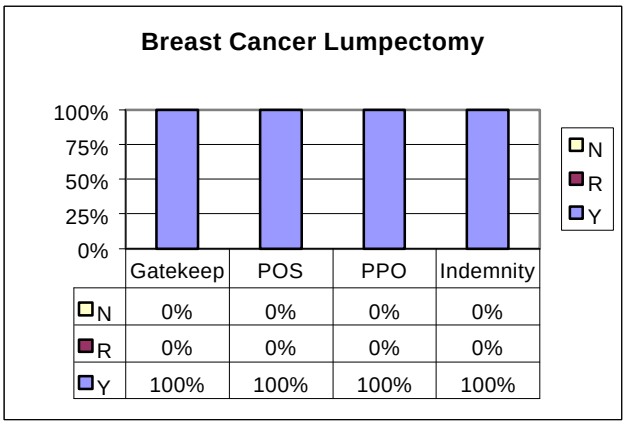
| Testicular Cancer Screening | Gatekeep | POS | PPO | Indemnit |
|---|---|---|---|---|
| N | 0% | 0% | 6% | 0% |
| R | 4% | 8% | 22% | 14% |
| Y | 96% | 92% | 72% | 86% |

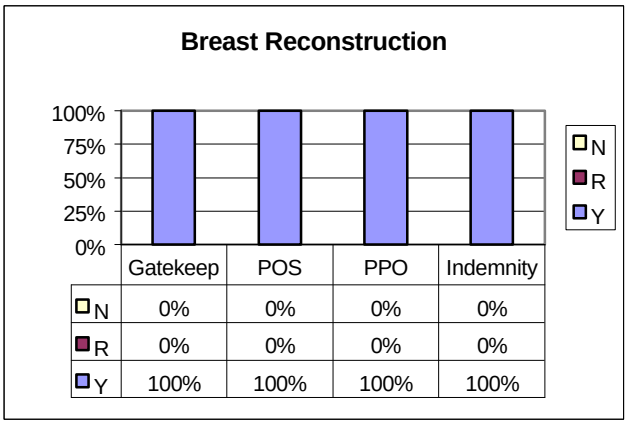
| Cervical Cancer Screening | Gatekeep | POS | PPO | Indemnity |
|---|---|---|---|---|
| N | 0% | 0% | 6% | 0% |
| R | 0% | 0% | 22% | 14% |
| Y | 100% | 100% | 72% | 86% |

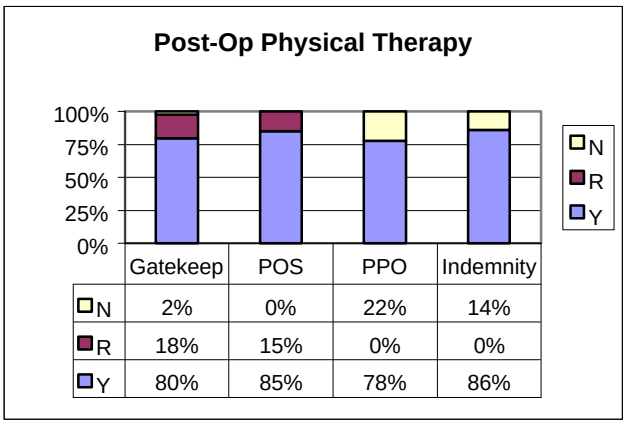
| Ovarian Cancer Screening | Gatekeep | POS | PPO | Indemnity |
|---|---|---|---|---|
| N | 4% | 0% | 6% | 0% |
| R | 0% | 8% | 22% | 14% |
| Y | 96% | 92% | 72% | 86% |

[a] Breast cancer screening was addressed in the Gynecologic Services section.




**Total Coverage (Routine plus Restricted Responses)**

These services have one of the highest coverage rates of any of the survey categories. Coverage of these screening and treatment services ranges from 94% to 100%.

All plans cover breast cancer mastectomy, lumpectomy, and breast reconstruction on a routine basis. Most plans (93%, n = 76/82) also cover post-operative physical therapy rehabilitative care; several do so under a rehabilitation benefit.

All the surveyed plans of 11 carriers (92%) cover the core services (i.e., prostate, testicular, cervical, and ovarian cancer screening). Ninety-nine percent of all plans (n = 82/83) cover these core services: 94% of PPO plans, and all (100%) of the 'gatekeeper', indemnity, and POS plans.

A total of 1,318,373 male and female enrollees have coverage for these core services, of whom an estimated 1,021,858 are aged 15 and over. This number represents 95% of all hypothetically eligible males and females over the age of 15 in the total plan enrollment of 1,076,114 women and men in this age group. Seventy-one percent of eligible individuals in PPO plans and all (100%) eligible individuals in 'gatekeeper', POS, and indemnity plans have coverage for these core services.

**Restrictions**

The service coverage restrictions described by the carriers pertained to overall wellness or preventive screening benefit limits, such as $45 per outpatient visit, or up to $200 - $250 per year caps.

**Rider / Direct Access / Copayment**

All surveyed plans cover these services as part of the basic benefit. Carriers report that women are guaranteed direct access to these services (women are allowed by state statute to self-refer for these services). Men must go through their primary care provider (PCP) or other 'gatekeeper' for their screening services. Most 'gatekeeper', POS, and PPO plans require standard copays, while 29% of indemnity plans do so.

**National Comparison**

The AGI study did not include questions regarding these services and so cannot provide national comparison.

### *Major Findings*

As noted previously, mammography screening is mandated as a health contract benefit in Washington, as is reconstructive breast surgery (RCW 48.44.330). Post-operative rehabilitative physical therapy following a breast-cancer related surgery is not mandated, and the survey reveals that a few carriers' plans do not cover this service.

# Sexually Transmitted Diseases

This section of the survey asked about coverage for sexual health history taking, sexual health counseling, sexually transmitted disease (STD) screening, diagnosis, and treatment.

Based on national guidelines[61] and provider responses, minimum core services were defined as STD screening, diagnosis, and treatment.

## *Background*

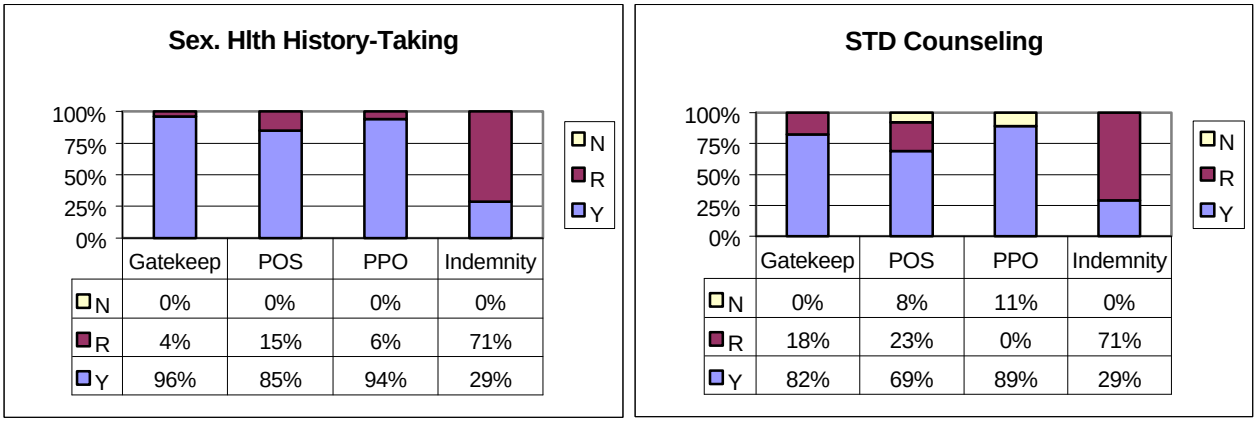
The burden of STDs takes a large, though often unrecognized toll, on a community's health. The financial and social impact of preventing STDs can be enormous. It has been estimated, for example, that preventing 100 cases of syphilis in high-risk patients can prevent 1200 HIV infections over a ten-year period.[62] Screening for early detection and treatment of STDs is cost-effective: spending one dollar to treat chlamydia will save $12 in later costs.[63] Managed care organizations are being encouraged to take a population-based approach to their 'covered lives' by encouraging their providers to routinely screen and treat for STDs.[64]

Data regarding sexual behavior, such as the age of sexual initiation and rates of contraceptive use, show that a significant amount of unprotected sex[a] occurs in all age groups. Of great concern is sexual risk taking among adolescents. Half of all HIV infection is estimated to occur among people under the age of 25, and two-thirds of all other STDs.[65] While rates of adolescent sexual activity appear to have leveled off in recent years, national data show that 56% of young women, and 73% of young men have engaged in sexual intercourse by age 18.[66] Yet 63% of sexually active girls 15 - 19 years old did not use condoms at last intercourse.[67]

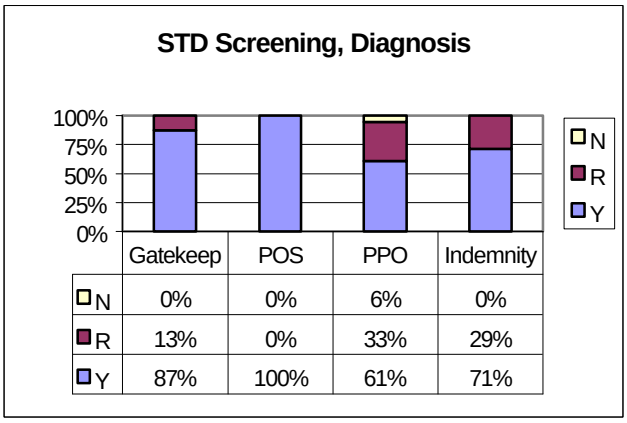
## *Survey Findings*

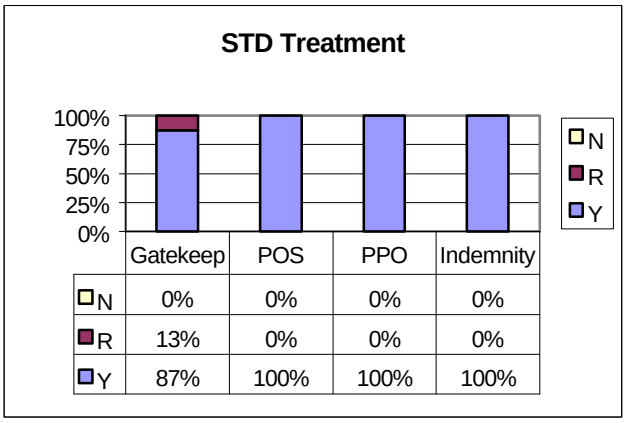
Please see Figure S-1 for a visual overview of reported service coverage in each plan type, by whether it is covered routinely ('Y'), on a restricted basis ('R'), or not at all ('N').

**Figure S-1: STD Service Coverage, By Plan Type**




[a] That is, sex without a condom or other barrier method to prevent STDs.




**Total Coverage (Routine plus Restricted Responses)**

STD counseling is covered by 29% of indemnity, 89% of PPO, 92% of POS, and 100% of 'gatekeeper' plans. STD screening is covered at a rate of 94% (PPO) to 100% ('gatekeeper', indemnity, and POS) plans. STD treatment is covered by all plans (100%).

All the plans of 11 carriers (92%) cover the core services (i.e., STD screening, diagnosis, and treatment). Ninety-nine percent of all plans (n = 82/83) cover these services: 94% of PPO plans, and all (100%) of the 'gatekeeper', indemnity, and POS plans.

A total of 1,318,373 male and female enrollees have coverage for these core services, of whom an estimated 1,021,858 are aged 15 and over. This number represents 95% of all hypothetically eligible males and females over the age of 15 in the sample. Seventy-one percent of eligible individuals in PPO plans and all (100%) eligible individuals in 'gatekeeper', POS, and indemnity plans have coverage for these core services.

**Restrictions**

While most plans routinely cover STD screening, some do so on a restricted basis (e.g., there is a $200 per year preventive service limit for Premera, and a $250 per year limit for John Alden plans). Some of the Group Health plans utilize a three-month pre-existing condition benefit wait period (though these products will cover 60% of costs incurred during the wait period). Some plans limit the number of counseling visits, which are considered to be under a mental health benefit if billed as a service separate from the office visit.

**Rider / Wait Period / Age Restrictions / Direct Access / Copayment**

All plans include these services as part of the basic benefit. No plans impose any age restrictions on these services. Two plans of Providence Health Care do not allow self-referral. Most 'gatekeeper', POS, and PPO plans require standard copays; most indemnity plans do not.

**National Comparison**

The AGI study did not include questions regarding these services and so cannot provide national comparison.

### *Major Findings*

While most carriers surveyed indicated that sexual health history taking is covered as part of an office visit, there is no way to track whether it in fact is being performed as national guidelines recommend. Sexual health and STD prevention counseling is not covered as a separate, billable service (only as incident to an office visit or as a separate mental health visit). This may serve as a disincentive for providers to spend time with patients in helping them to assess their risk behaviors and to learn the skills needed to make behavioral changes to reduce their chance of acquiring or transmitting a STD.

# HIV/AIDS

This section of the survey asked about coverage for HIV counseling, testing, and treatment including the use of protease inhibitor combination therapies.

Based on national guidelines[68] and provider responses, minimum core services were defined as HIV counseling and testing, and treatment.

## *Background*

From 40,000 to 60,000 new HIV infections are estimated to occur each year in the US. While recent medical advances are helping many persons with HIV disease to live longer, HIV/AIDS continues to be a serious public health problem, with disturbing rates of infection among adolescents (especially gay youth), women, injecting drug users (IDUs) and in communities of color.

AIDS is the third leading cause of death for American women ages 25 to 44 and the leading cause of death to African American women in this age group. The CDC recommends universal counseling and voluntary HIV testing of pregnant women so that they can be offered treatments for themselves and for prevention of perinatal HIV transmission. (The CDC has stated that implementation of these screening recommendations helps account for the fact that the number of children who acquire HIV from their mothers declined by 27% between 1992 and 1995.[69])

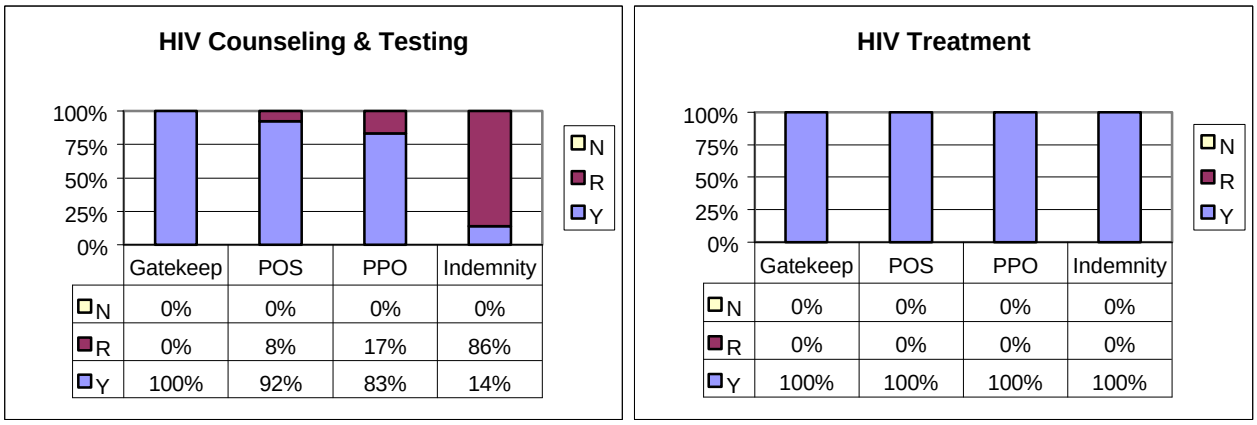
HIV counseling and testing is also important for sexually active and substance-using individuals. While there are a number of HIV-specific and other publicly-funded sites for HIV testing, most HIV testing in the United States takes place in private physicians' offices. Plan coverage of counseling and testing thus is germane.

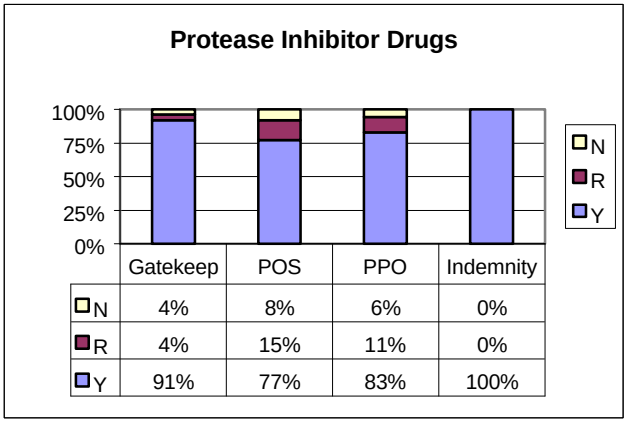
Protease inhibitor drugs used in three-to-four "cocktail" combinations have proven to be effective in reducing the AIDS death rate, improving the quality of life of HIV-positive people, and helping reduce transmission by lowering the amount of virus in a person's body. Carriers were asked whether their drug formularies cover protease inhibitors.

## *Survey Findings*

Please see Figure H-1 for a visual overview of reported service coverage in each plan type, by whether it is covered routinely ('Y'), on a restricted basis ('R'), or not at all ('N').

**Figure H-1: HIV Service Coverage, By Plan Type**






| | Gatekeep | POS | PPO | Indemnity |
|---|---|---|---|---|
| N | 4% | 8% | 6% | 0% |
| R | 4% | 15% | 11% | 0% |
| Y | 91% | 77% | 83% | 100% |

**Total Coverage (Routine plus Restricted Responses)**

All the plans of 12 carriers (100%) cover the core services (i.e., as HIV counseling and testing, and treatment). Encouragingly, 100% of all plans (n = 83/83) and of all plan types cover these services.

The majority of plans (95%; n = 79/83) report that the formulary of drugs for HIV/AIDS treatment covers the use of protease inhibitors.

A total of 1,388,373 male and female enrollees have coverage for these core services, of whom an estimated 1,076,114 are aged 15 and over. This number represents 100% of all hypothetically eligible males and females over the age of 15 in the sample. All (100%) eligible individuals in 'gatekeeper', POS, PPO, and indemnity plans have coverage for these core services.

**Restrictions**

In some plans protease inhibitors are covered only if the optional prescription benefit is purchased. All of Northwest Medical Bureau's plans cover the HIV test but not counseling.

**Rider / Wait Period / Age Restrictions / Access / Copayment**

Most plans cover these services as part of the basic benefit, though 38% of PPO plans surveyed offer this coverage as a rider. No plans impose a benefit wait period. Direct access was guaranteed by most plans (n = 77/83). Most plans apply a standard copay.

**National Comparison**

The AGI study did not include questions regarding these services and so cannot provide national comparison.

### *Major Findings*

Counseling to help individuals avoid infection can be useful and appears to be covered in most cases.

# Sterilization

This section of the survey asked about coverage for vasectomy, laparoscopic and vaginal/abdominal tubal ligation, hysterectomy, and counseling.

Based on provider responses, minimum core services were defined as vasectomy, laparoscopic and vaginal/abdominal tubal ligation, and hysterectomy.[a]

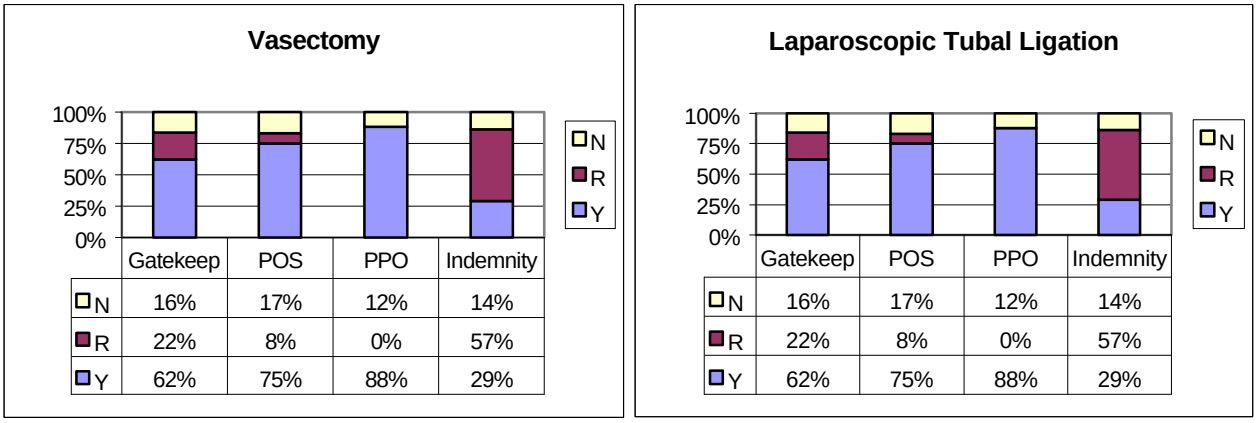
## *Background*

Sterilization is the most common method of birth control in the United States. It is used by almost four out of ten individuals who contracept, a higher rate than in other industrialized nations. It has been speculated that this may be due in part to the lack of coverage for other, reversible methods of contraception.[70] Surgical sterilization also tends to be the type of contraception most often covered by private health plans (85 - 90% in one national study).[71]

## *Survey Findings*

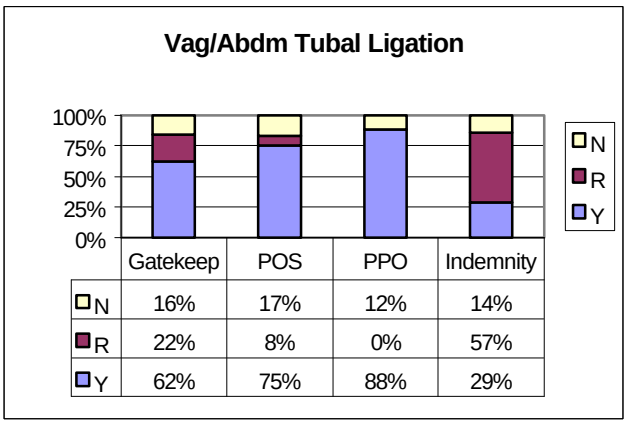
Please see Figure ST-1 for a visual overview of reported service coverage in each plan type, by whether it is covered routinely ('Y'), on a restricted basis ('R'), or not at all ('N').

**Figure ST-1: Sterilization Service Coverage, By Plan Type**

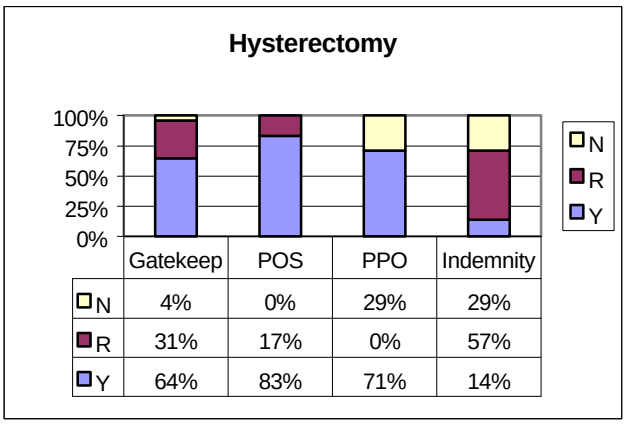



| | Gatekeep | POS | PPO | Indemnity |
|---|---|---|---|---|
| N | 16% | 17% | 12% | 14% |
| R | 22% | 8% | 0% | 57% |
| Y | 62% | 75% | 88% | 29% |

[a] Most procedures are now done on an outpatient basis. Hysterectomy should not be done solely for sterilization purposes, but may be done for medically-indicated reasons, or incidental to another procedure. Most carriers surveyed indicated that they would cover hysterectomy, though several pointed out that they do so only after utilization or medical review.




| | Gatekeep | POS | PPO | Indemnity |
|---|---|---|---|---|
| N | 16% | 17% | 12% | 14% |
| R | 22% | 8% | 0% | 57% |
| Y | 62% | 75% | 88% | 29% |




| | Gatekeep | POS | PPO | Indemnity |
|---|---|---|---|---|
| N | 4% | 0% | 29% | 29% |
| R | 31% | 17% | 0% | 57% |
| Y | 64% | 83% | 71% | 14% |

**Total Coverage (Routine plus Restricted Responses)**

All the plans of 6 carriers (50%) cover these core services. Seventy-six percent of all plans (n = 62/81) cover the core services (i.e., vasectomy, laparoscopic and vaginal/abdominal tubal ligation, and hysterectomy): 65% of PPO plans, 71% of indemnity, 80% of 'gatekeeper', and 83% of the POS plans.

A total of 867,343 male and female enrollees have coverage for these core services, of whom an estimated 386,479 are aged 15 and over. This number represents representing 63% of all hypothetically eligible males and females ages 15 – 44 in the total plan enrollment of 614,293 women and men in this age group. Approximately 43% of eligible individuals in POS plans, 55% in 'gatekeeper' plans, 97% in indemnity plans, and 98% in PPO plans have coverage for these core services.

**Restrictions**

The service coverage restriction most often described by the carriers was related to age criteria, with coverage for those under the age of consent restricted to medical necessity. Some plans require a higher than standard copay ($50 for vasectomy, $150 for tubal ligation); some tie the coverage limit to the overall maternity benefit limit.

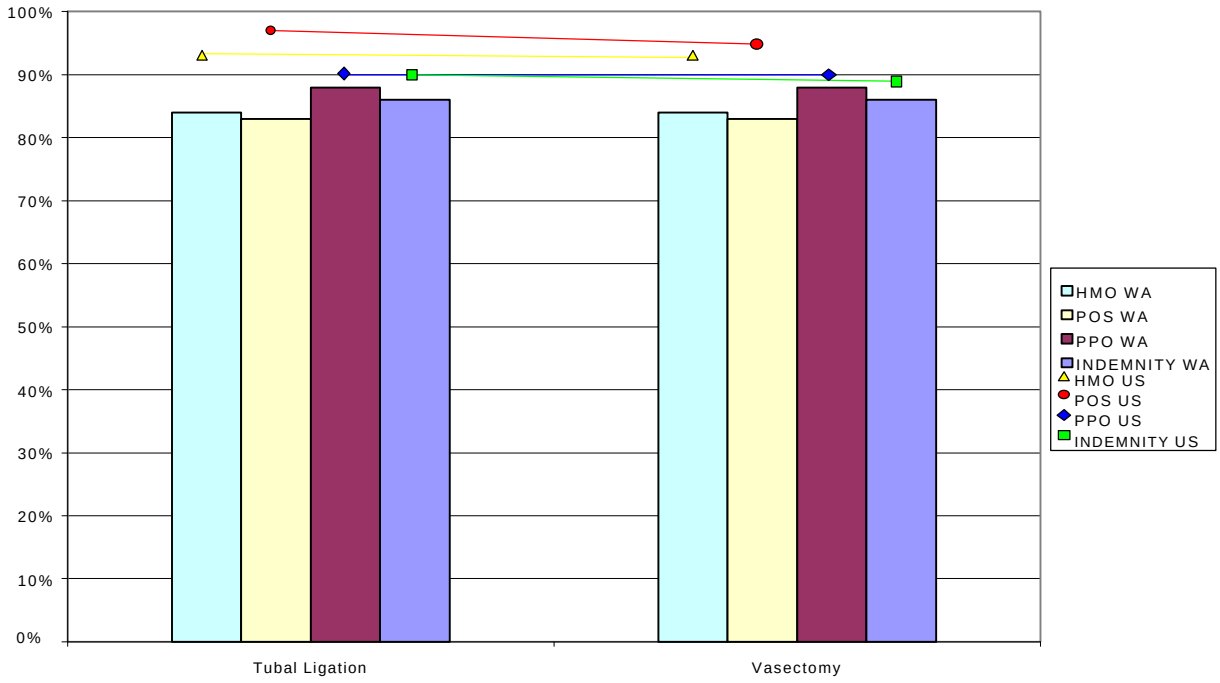
**Rider / Age Restrictions / Direct Access / Copayment**

POS, PPO, and indemnity plans all cover these services as part of the basic benefit; 13% of 'gatekeeper' plans offer sterilization as an optional benefit. Twelve plans report that they follow age restriction guidelines, such as that a patient must be 21 years of age to be eligible for sterilization. At least one carrier requires a waiting period of at least six months for sterilization procedures. All plans allow direct access. Copays are charged for most 'gatekeeper', POS, and PPO plans.

**National Comparison**

The indemnity and PPO plans surveyed provide coverage at a level comparable to the 1996 national average. POS and 'gatekeeper' plans cover at a rate somewhat lower than the national average.

**Figure ST-2: Sterilization Coverage By Plan Type, Washington and US 1998**




### *Major Findings*

Despite the popularity of sterilization as a birth control method, 13 - 18% of all plans types surveyed do *not* cover sterilization procedures.

## Health Insurer Privacy Policies

### *Background*

Both adolescents and adult women may delay seeking time-sensitive reproductive and sexual health services if they do not feel confident that the care they receive will be kept confidential. As pointed out by the Center for Reproductive Law and Policy, a one-day lapse in contraception can result in an unintended pregnancy; a week's delay in obtaining an abortion can increase health risks; lost opportunities to screen, treat, and prevent STDs can lead to infertility, ectopic pregnancy, cervical cancer, and HIV disease; delays in prenatal care can lead to low birthweight and other problems for newborns.[72]

State laws protecting minor healthcare privacy may be routinely violated. Protecting medical records does not protect privacy rights. Routine insurance transactions and procedures can violate privacy laws.[73] Insurer practices of sending billing statements or explanation of benefit (EOB) notices to parents undercut efforts to maintain confidentiality by clinicians and clinics.[74]

Victims of domestic violence likewise may be in personal danger if the abusing partner or spouse is given information regarding the victim's health utilization. It is possible that some domestic violence victims may avoid seeking necessary health care due to confidentiality concerns. The King County Health Action Plan has found that access to health services for victims of domestic violence is a significant unmet need for this group of women.[75] Spouses who have been abused by their partners may be afraid to seek care for fear that the bill, EOB form, confirmation of appointment, or other paperwork from the health insurance carrier may be received or discovered by the abusive partner.

Washington State laws require confidentiality with respect to certain kinds of health care records and health care services. The most direct and comprehensive is chapter 70.02 RCW entitled Medical Records - Health Care Information Access and Disclosure. This chapter primarily governs release of health information by health care facilities and health care professionals. Other statutes govern the release of information relating to specific types of health care services:

- RCW 71.34.200 requires the confidentiality of minor mental health records.
- RCW 70.24.105 requires the confidentiality of health records relating to sexually transmitted diseases.
- RCW 70.24.110 permits minors to consent to health care for sexually transmitted diseases without parental consent or parental financial liability for such care.
- RCW 70.96A.150 requires the confidentiality of health records relating to treatment for chemical dependency.
- RCW 70.96A.095 permits minors to consent to certain types of treatment for chemical dependency without parental consent or parental financial liability for such care.

These laws provide for disclosure of health information for purposes of insurance coverage; but, the statutes vary in their degree of specificity or restrictions on disclosure. For example, while the Medical Records Act requires authorization for release of medical records for insurance coverage, no particular provision governs insurer procedures to protect privacy. In contrast, restrictions on the release of information relating to sexually transmitted diseases specifically directs insurers to limit use

and disclosure of information to those involved in the evaluation and payment of a claim for benefits [RCW 70.24.105].

### *Survey Findings*

While all carriers surveyed have some kind of policy with respect to health information privacy, the degree of privacy protection varies widely. The survey found that some insurers have limited or no privacy policies on critical issues like compliance with state minor access laws.

Only two carriers had detailed privacy policies. Group Health Cooperative and King County Medical (now Regence) have developed comprehensive health care information procedures and given notice to the public of these practices. The extensive response by Group Health may be explained, in part, by its responsibilities as a provider of health services: Group Health employs health care professionals and operates hospitals. Other carriers' less extensive policies may be due to a reliance upon the health care professional to protect patient confidentiality.

No survey respondent indicated privacy policies that would ensure that routine insurance transactions would not inadvertently disclose health information. One respondent, First Choice, recognized this problem by noting that it had changed its EOB form sent to policyholders to non-descriptive health service codes. However, the mere notice itself explaining that a minor accessed a health service could cause parents to question the teen and thereby thwart efforts to ensure privacy.

All respondents require employees to sign confidentiality agreements. All contracts between insurers and health care providers contain a clause governing insurer access to medical records and provider responsibility to follow state and federal privacy laws. Apart from these similarities, there is no consistency among carriers in the collection, use, and disclosure of health information. In some cases, responses raise serious questions as to how insurers can comply with existing state law given the limited nature of their systems in place to protect privacy.

### *Major Findings*

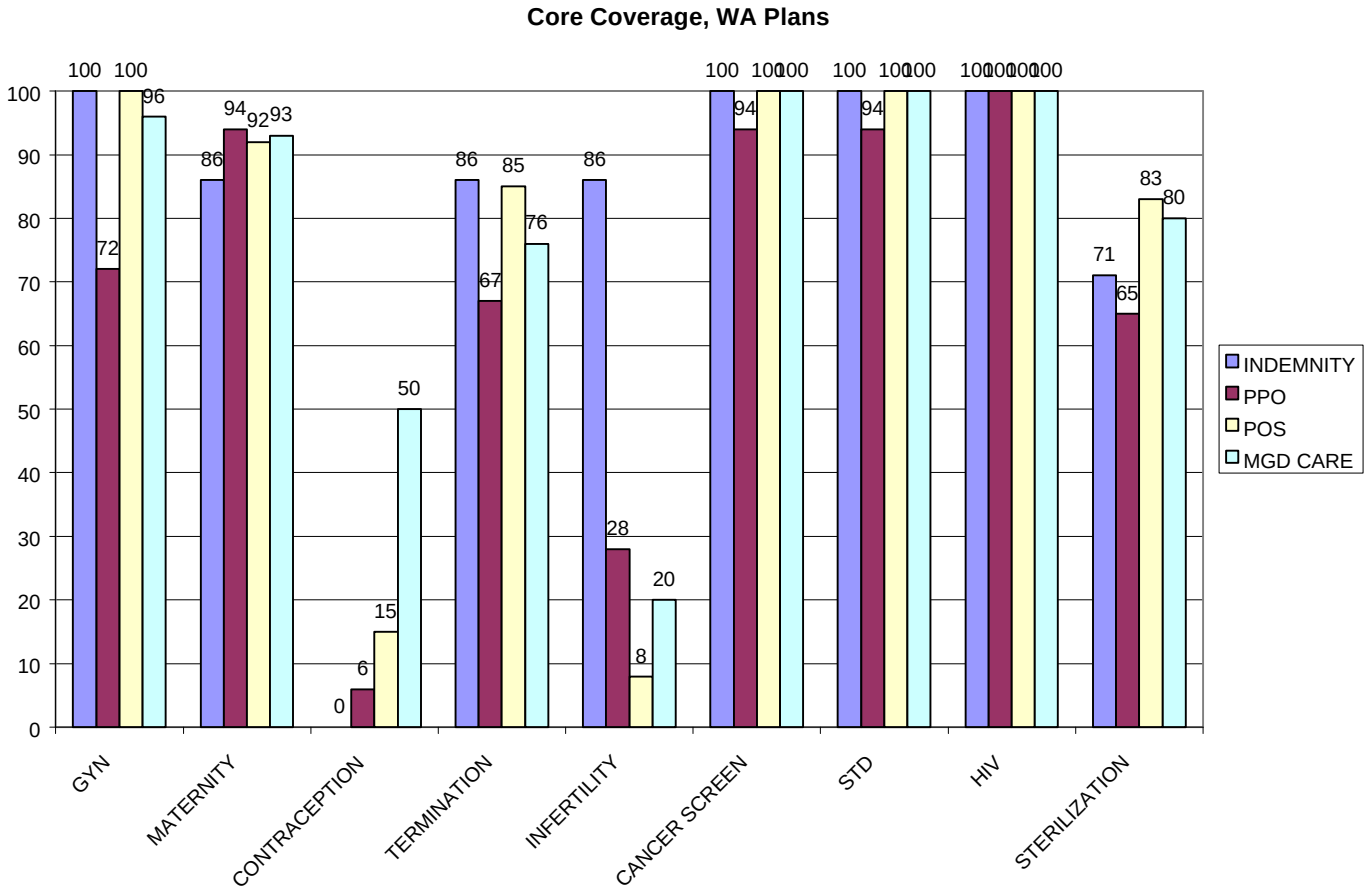
Almost no carriers have any specific policies in place to prevent inadvertent disclosure of sensitive health information through operational practices.

# CONCLUSIONS

This survey of private and public health insurance coverage of reproductive and sexual health benefits is the first to document state-level information regarding these important services.

The health services most often of concern to sexually active women and men in Washington appear to be available through at least some of the sampled carriers' best selling plans. However, the survey identified a wide range in market offerings of these services. To the extent that people rely on market forces to promote access to health care, the survey data make clear that such access is not occurring for several key components of reproductive health.

**Figure 3: Percent of Washington Plans Covering All Core Services**



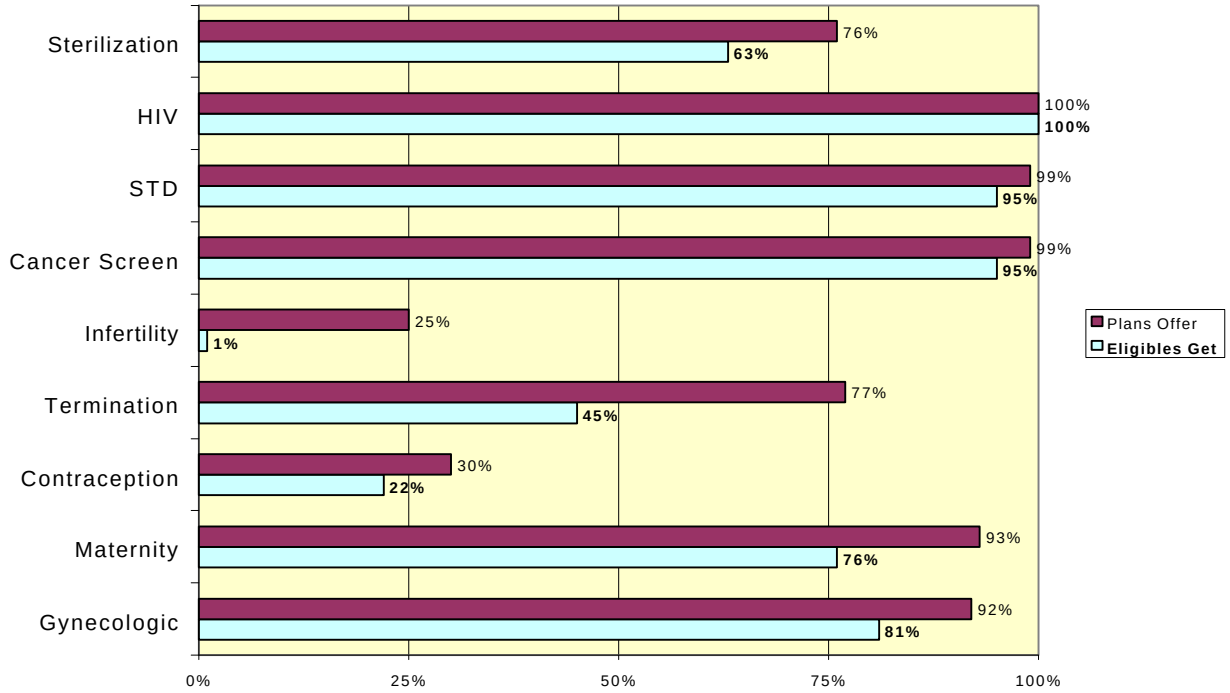

As Figure 3 shows, there are wide variations in coverage by plan type. If having insurance promotes access to health care, insurance coverage may help promote important public health goals such as preventing unintended pregnancies or STDs including HIV. The most striking finding is the degree to which coverage for contraception and family planning services, devices, and medications lags behind other health service coverage.

While nearly all plans offer gynecologic, maternity, reproductive cancer screening, STD, and HIV services, there are restrictions or outright exclusions on coverage of contraception and family planning services, infertility treatment, and counseling related to reproductive and sexual health concerns. This latter may be a concern in the area of STDs and HIV -- which carriers indicate are covered for treatment -- but for which counseling may be helpful in earlier identification or prevention of these conditions. Sterilization and pregnancy termination are covered by nearly three out of four plans.

Coverage of prenatal care for teen dependents of enrollees also is inconsistent among plans. In addition, several important questions regarding compliance with some laws that promote access were identified, including coverage for newborns of dependents.

In general, in Washington State the 'gatekeeper' managed care plans tend to have the highest rates of routine and restricted coverage for reproductive health services, while indemnity and PPO plans have the lowest rates of coverage. Point-of-service plans cover gynecologic, maternity, termination, and sterilization services at a relatively high rate, but provide inadequate coverage for contraceptive services.

**Figure 4: Estimated Eligible Individuals with Core Coverage**




While a high percentage of health *plans* cover many of the reproductive health services essential to women and men, the percentage of *individuals* who actually receive coverage for these core services is lower (Figure 4). Some plans with relatively large enrollment provide inadequate coverage of these services. As many as one in five potentially eligible women with insurance do *not* receive core coverage for routine gynecological care. One in four women do not have core maternity coverage. Four in five women have no core coverage for contraceptives. One in two women are not covered for pregnancy termination. One in three women and men do not have coverage for sterilization. Finally, no health plan provides routine coverage for infertility treatment.

# APPENDIX: SURVEY TOOL

In most sections of the survey, carriers were asked whether enrollees had "Direct Access", i.e., are able to self-refer to a women's health provider, as mandated by RCW 48.42.100. Responses were coded as 'Yes' if women were able to self-refer, though in most cases men must go through a primary care provider. Carriers were asked whether there are "Copays, Coinsurance, or Deductibles" associated with the service. Responses were coded as 'Yes' if any copay applied; in many cases this was the standard office visit or prescription copay. A note was made in the "Notes" column if a specific or higher than standard copay was applicable. "Counseling" services were generally coded as 'R' for restricted if carriers cover it only as part of the regular office visit; when covered as a separately-billable service it was coded as a 'Yes'. Carriers were asked in the Maternity, Infertility, and HIV sections if any benefit waiting period applied to these services. It was explained that this must be coded as a 'Yes' if any period beyond the three-month pre-existing condition exclusion allowed carriers under RCW 48.43.025 was being imposed. Where specific services were not part of the standard benefit package, carriers were asked if they offer these services as a rider. For those plans with relevant riders, carriers were further asked to estimate the percent of enrollees who have that rider. In the Infertility section, this estimation was applied to those who have access to infertility diagnosis and treatment; in the Pregnancy Termination section, to refer to those who have a rider covering elective termination.

**ROUTINE GYNECOLOCIGAL CARE**

List your 5 best selling group plans, and 2 best selling individual plans, and describe whether the benefit includes the core services listed below by indicating 'Yes/No'. If these services are covered only as a rider, please mark 'Yes' in the "Rider" column. If the benefit is offered but has restrictions, mark 'R*' and describe Restriction(s) in last column. Describe any additional services that are part of the package in the "Notes" column. Under "Plan Classification", indicate whether your plan is a 'PPO', 'POS', 'MGD CARE' (uses PCP & provider network) or 'INDM' (indemnity) model.

**CARRIER NAME:**
**PLAN NAME:**
**PLAN TYPE:**
**PLAN CLASS:**

**# ENROLLEES/SUBSCRIBERS:**
**# MALE AND FEMALE**
**# SPOUSE:**
**# MALE AND FEMALE:**
**# DEPENDENTS**

**PAP SMEAR CPT 88150**
**Yes No R***

**CHLAMYDIA CPT 87110**
**Yes No R***

**MAMMOGRAM CPT 76092**
**Yes No R***

**ANNUAL EXAM CPT 99395**
**Yes No R***

**CLINICAL BREAST EXAM**
**Yes No R***

**SEX HEALTH COUNSELING CPT 99401-4**
**Yes No R***

**COVERED AS A RIDER**
**Yes No R***

**HOW MANY, % WITH BENEFIT/RIDER**

**AGE RESTRICTIONS**
**Yes No R***

**DIRECT ACCESS**
**Yes No R***

**COPAY/COINSURANCE /DEDUCTIBLES**
**Yes No R***

***RESTRICTIONS / NOTES (Describe)**

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**MATERNITY**

List your 5 best selling group plans, and 2 best selling individual plans, and describe whether the benefit includes the core services listed below by indicating 'Yes/No'. If these services are covered only as a rider, please mark 'Yes' in the "Rider" column. If the benefit is offered but has restrictions, mark 'R*' and describe Restriction(s) in last column. Describe any additional services that are part of the package in the "Notes" column. Under "Plan Classification", indicate whether your plan is a 'PPO', 'POS', 'MGD CARE' (uses PCP & provider network) or 'INDM' (indemnity) model.

**CARRIER NAME:**
**PLAN NAME:**
**PLAN TYPE:**
**PLAN CLASS:**

**# ENROLLEES/SUBSCRIBERS:**
**# MALE AND FEMALE**
**# SPOUSE:**
**# MALE AND FEMALE:**
**# DEPENDENTS**

**PRE-CONCEPTUAL COUNSELING CPT 99420**
**Yes No R***

**PRENATAL TESTING**
**Yes No R***

**PRENATAL/OB CARE CPT 59400:**
**Yes No R***

**DELIVERY HOSPITAL**
**Yes No R***

**DELIVERY HOME**
**Yes No R***

**DELIVERY BIRTH UNIT**
**Yes No R***

**POST-PARTUM CARE**
**Yes No R***

**NEWBORN CARE**
**Yes No R***

**COVERED AS A RIDER**
**Yes No R***

**HOW MANY, % WITH BENEFIT/RIDER**

**RESTRICTIONS ON THE NUMBER OF BIRTHS (DOLLAR OR #)**
**Yes No R***

**21-DAY POST PARTUM CARE OF CHILD OF DEPENDENTS**
**Yes No R***

**PRENATAL CARE OF TEEN DEPENDENTS**
**Yes No R***

**BENEFIT WAIT PERIOD**
**Yes No R***

**DIRECT ACCESS**
**Yes No R***

**COPAY/COINS/DEDUCTIBLE**
**Yes No R***

***RESTRICTIONS / NOTES (Describe)**

**CONTRACEPTION AND FAMILY PLANNING**

List your 5 best selling group plans, and 2 best selling individual plans, and describe whether the benefit includes the core services listed below by indicating 'Yes/No'. If these services are covered only as a rider, please mark 'Yes' in the "Rider" column. If the benefit is offered but has restrictions, mark 'R*' and describe Restriction(s) in last column. Describe any additional services that are part of the package in the "Notes" column. Under "Plan Classification", indicate whether your plan is a 'PPO', 'POS', 'MGD CARE' (uses PCP & provider network) or 'INDM' (indemnity) model.

**CARRIER NAME:**
**PLAN NAME:**
**PLAN TYPE:**
**PLAN CLASS:**

**# ENROLLEES/SUBSCRIBERS:**
**# MALE AND FEMALE**
**# SPOUSE:**
**# MALE AND FEMALE:**
**# DEPENDENTS**

**CONTRA COUNSEL**
**CPT 99401**
**Yes No R***

**OTC CONTRACEPTION**
**Yes No R***

**IUD DEVICE:**
**Yes No R***

**IUD INSERT**
**CPT 58300**
**Yes No R***

**IUD REMOVAL**
**Yes No R***

**DIAPHRAGM DEVICE**
**Yes No R***

**DIAPHRAGM/CAP FIT**
**CPT 57170**
**Yes No R***

**NORPLANT DEVICE**
**Yes No R***

**NORPLANT INSERT**
**CPT 11975**
**Yes No R***

**NORPLANT REMOVAL**
**CPT 11976**
**Yes No R***

**DPMA INJECT**
**CPT 01050**
**Yes No R***

**ORAL CONTRACEPTIVE PILLS**
**Yes No R***

**EMERGENCY CONTRACEPTION**
**Yes No R***

**COVER AS RIDER**
**Yes No R***

**HOW MANY, % WITH BENEFIT/RIDER**

**DIRECT ACCESS**
**Yes No R***

**COPAY/COINS/DEDUCT**
**Yes No R***

***RESTRICTIONS / NOTES (Describe)**

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**PREGNANCY TERMINATION**

List your 5 best selling group plans, and 2 best selling individual plans, and describe whether the benefit includes the core services listed below by indicating 'Yes/No'. If these services are covered only as a rider, please mark 'Yes' in the "Rider" column. If the benefit is offered but has restrictions, mark 'R*' and describe Restriction(s) in last column. Describe any additional services that are part of the package in the "Notes" column. Under "Plan Classification", indicate whether your plan is a 'PPO', 'POS', 'MGD CARE' (uses PCP & provider network) or 'INDM' (indemnity) model. Please indicate if there are differences in coverage for voluntary (elective, therapeutic) and medically necessary / life-threatening termination of pregnancies.

**CARRIER NAME:**
**PLAN NAME:**
**PLAN TYPE:**
**PLAN CLASS:**

**# ENROLLEES/SUBSCRIBERS:**
**# MALE AND FEMALE**
**# SPOUSE:**
**# MALE AND FEMALE:**
**# DEPENDENTS**

**ELECTIVE TERMINATION**
**Yes No R***

**MED. NECESSARY/LIFE THREATENING**
**Yes No R***

**COVERED AS A RIDER**
**Yes No R***

**HOW MANY, % WITH BENEFIT/RIDER**

**ALLOW EMPLOYER TO EXCLUDE BENEFIT**
**Yes No R***

**ALLOW PROVIDER TO OPT OUT**
**Yes No R***

**DIRECT ACCESS**
**Yes No R***

**COPAY/COINS/DEDUCT**
**Yes No R***

***RESTRICTIONS/NOTES (Describe)**

**INFERTILITY**

List your 5 best selling group plans, and 2 best selling individual plans, and describe whether the benefit includes the core services listed below by indicating 'Yes/No'. If these services are covered only as a rider, please mark 'Yes' in the "Rider" column. If the benefit is offered but has restrictions, mark 'R*' and describe Restriction(s) in last column. Describe any additional services that are part of the package in the "Notes" column. Under "Plan Classification", indicate whether your plan is a 'PPO', 'POS', 'MGD CARE' (uses PCP & provider network) or 'INDM' (indemnity) model.

**CARRIER NAME:**
**PLAN NAME:**
**PLAN TYPE:**
**PLAN CLASS:**

**# ENROLLEES/SUBSCRIBERS:**
**# MALE AND FEMALE**
**# SPOUSE:**
**# MALE AND FEMALE:**
**# DEPENDENTS**

**INFERTILITY DIAGNOSIS**
**Yes No R***

**INFERTILITY TREATMENT**
**Yes No R***

**ENDOMETRIAL BIOPSY**
**CPT 58100**
**Yes No R***

**ENDOMETRIOSIS TREATMENT**
**Yes No R***

**SEMEN ANALYSIS**
**Yes No R***

**ASSISTED REPRODUCTIVE TECHNOLOGIES**
**Yes No R***

**FERTILITY DRUGS**
**Yes No R***

**COVERED AS A RIDER**
**Yes No R***

**HOW MANY, % WITH BENEFIT/RIDER**

**BENEFIT WAIT PERIOD**
**Yes No R***

**AGE RESTRICTIONS**
**Yes No R***

**DIRECT ACCESS**
**Yes No R***

**COPAY/COINS/DEDUCT**
**Yes No R***

***RESTRICTIONS/NOTES (Describe)**

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**REPRODUCTIVE CANCER SCREENING**

List your 5 best selling group plans, and 2 best selling individual plans, and describe whether the benefit includes the core services listed below by indicating 'Yes/No'. If these services are covered only as a rider, please mark 'Yes' in the "Rider" column. If the benefit is offered but has restrictions, mark 'R*' and describe Restriction(s) in last column. Describe any additional services that are part of the package in the "Notes" column. Under "Plan Classification", indicate whether your plan is a 'PPO', 'POS', 'MGD CARE' (uses PCP & provider network) or 'INDM' (indemnity) model.

**CARRIER NAME:**
**PLAN NAME:**
**PLAN TYPE:**
**PLAN CLASS:**

**# ENROLLEES/SUBSCRIBERS:**
**# MALE AND FEMALE**
**# SPOUSE:**
**# MALE AND FEMALE:**
**# DEPENDENTS**

**PROSTATE CANCER SCREEN**
**Yes No R***

**TESTICULAR CANCER SCREEN**
**Yes No R***

**CERVICAL CANCER SCREEN**
**Yes No R***

**OVARIAN CANCER SCREEN**
**Yes No R***

**BREAST CANCER SCREEN**
**Yes No R***

**BREAST CANCER LUMPECTOMY**
**Yes No R***

**BREAST RECONSTRUCTION**
**Yes No R***

**POST-OP PHYSICAL THERAPY**
**Yes No R***

**COVERED AS A RIDER**
**Yes No R***

**HOW MANY, % WITH BENEFIT/RIDER**

**DIRECT ACCESS**
**Yes No R***

**COPAY/COINS/DEDUCTIBLE**
**Yes No R***

***RESTRICTIONS/NOTES (Describe)**

**SEXUALLY TRANSMITTED DISEASES**

List your 5 best selling group plans, and 2 best selling individual plans, and describe whether the benefit includes the core services listed below by indicating 'Yes/No'. If these services are covered only as a rider, please mark 'Yes' in the "Rider" column. If the benefit is offered but has restrictions, mark 'R*' and describe Restriction(s) in last column. Describe any additional services that are part of the package in the "Notes" column. Under "Plan Classification", indicate whether your plan is a 'PPO', 'POS', 'MGD CARE' (uses PCP & provider network) or 'INDM' (indemnity) model.

**CARRIER NAME:**
**PLAN NAME:**
**PLAN TYPE:**
**PLAN CLASS:**

**# ENROLLEES/SUBSCRIBERS:**
**# MALE AND FEMALE**
**# SPOUSE:**
**# MALE AND FEMALE:**
**# DEPENDENTS**

**SEXUAL HEALTH COUNSELING**
**Yes No R***

**STD COUNSELING**
**Yes No R***

**STD TREATMENT**
**Yes No R***

**COVERED AS A RIDER**
**Yes No R***

**HOW MANY, % WITH BENEFIT/RIDER**

**AGE RESTRICTIONS**

**Yes No R***
**DIRECT ACCESS**
**Yes No R***

**COPAY/COINS/DEDUCT**
**Yes No R***

***RESTRICTIONS/NOTES (Describe)**

## HIV

List your 5 best selling group plans, and 2 best selling individual plans, and describe whether the benefit includes the core services listed below by indicating 'Yes/No'. If these services are covered only as a rider, please mark 'Yes' in the "Rider" column. If the benefit is offered but has restrictions, mark 'R*' and describe Restriction(s) in last column. Describe any additional services that are part of the package in the "Notes" column. Under "Plan Classification", indicate whether your plan is a 'PPO', 'POS', 'MGD CARE' (uses PCP & provider network) or 'INDM' (indemnity) model.

**CARRIER NAME:**
**PLAN NAME:**
**PLAN TYPE:**
**PLAN CLASS:**

**# ENROLLEES/SUBSCRIBERS:**
**# MALE AND FEMALE**
**# SPOUSE:**
**# MALE AND FEMALE:**
**# DEPENDENTS**

**HIV COUNSELING AND TESTING**
**Yes No R***
**HIV TREATMENT**

**Yes No R***

**FULL RX FORMULARY (PROTEASE)**
**Yes No R***

**COVERED AS A RIDER**
**Yes No R***

**HOW MANY, % WITH BENEFIT/RIDER**

**BENEFIT WAIT PERIOD**
**Yes No R***

**DIRECT ACCESS**
**Yes No R***

**COPAY/COINS/DEDUCTIBLE**
**Yes No R***

***RESTRICTIONS/NOTES (Describe)**

## STERILIZATION

List your 5 best selling group plans, and 2 best selling individual plans, and describe whether the benefit includes the core services listed below by indicating 'Yes/No'. If these services are covered only as a rider, please mark 'Yes' in the "Rider" column. If the benefit is offered but has restrictions, mark 'R*' and describe Restriction(s) in last column. Describe any additional services that are part of the package in the "Notes" column. Under "Plan Classification", indicate whether your plan is a 'PPO', 'POS', 'MGD CARE' (uses PCP & provider network) or 'INDM' (indemnity) model.

**CARRIER NAME:**
**PLAN NAME:**
**PLAN TYPE:**
**PLAN CLASS:**

**# ENROLLEES/SUBSCRIBERS:**
**# MALE AND FEMALE**
**# SPOUSE:**
**# MALE AND FEMALE:**
**# DEPENDENTS**

**VASECTOMY**
**CPT 55250**
**Yes No R***

**LAPAROSCOPICAL TUBAL LIGATION**
**Yes No R***

**HYSTERECTOMY**
**Yes No R***

**COUNSELING**
**Yes No R***

**COVERED AS A RIDER**
**Yes No R***

**HOW MANY, % WITH BENEFIT/RIDER**

**AGE RESTRICTIONS**
**Yes No R***

**DIRECT ACCESS**
**Yes No R***

**COPAY/COINS/DEDUCTIBLE**
**Yes No R***

***RESTRICTIONS/NOTES (DESCRIBE)**

## RESOURCES / REFERENCES

A Technical Report showing the original survey database is available in hard copy format. To order a copy, please contact:

Washington State Office of Insurance Commissioner
PO Box 40255
Olympia, WA 98504-0255

Phone: (360) 753-7300

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